Agency of Human Services
Department of Vermont Health Access (DVHA)
312 Hurricane Lane, Suite 201
Williston, VT 05495
802-879-8256

SEALED BID

INFORMATION TECHNOLOGY REQUEST FOR PROPOSAL

FOR Independent Verification and Validation (IV&V) for the Design, Development, and Implementation of a Medicaid Management Information System and Integrated Contact Center System and Services

(Procurement Schedule Amended 11/4/14)

Procurement Schedule	
RFP Release Date	August 22, 2014
Letter of Intent Due	August 29, 2014
Vendor's Questions Due	September 4, 2014
Dept. Responses to Vendor's Questions are Posted	September 10, 2014
Proposals Due/Closing Date	October 2, , 2014
Bid Opening	October 2, 2014
Tentative Vendor Selection Date	December 12, 2014 (AMENDED)
Tentative Contract Start Date	January 15, 2015 (AMENDED)

LOCATION OF BID OPENING: 312 Hurricane Lane, Suite 201, Williston, VT 05495

PLEASE BE ADVISED THAT ALL NOTIFICATIONS, RELEASES, AND AMENDMENTS ASSOCIATED WITH THIS RFP WILL BE POSTED AT:
http://www.vermontbidsystem.com
http://dvha.vermont.gov/administration/2013-requests-for-proposals

THE STATE WILL MAKE NO ATTEMPT TO CONTACT VENDORS WITH UPDATED INFORMATION. IT IS THE RESPONSIBILITY OF EACH VENDOR TO CHECK http://www.vermontbidsystem.com **AND THE DVHA RFP WEBSITE FOR ANY AND ALL NOTIFICATIONS, RELEASES AND AMENDMENTS ASSOCIATED WITH THE RFP.**

PURCHASING AGENT: Michelle A. Mosher
TELEPHONE: (802) 878-7957
E-MAIL: Michelle.Mosher@state.vt.us

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1.0 General Information

1.1 Introduction

The State of Vermont, Agency of Human Services, Department of Vermont Health Access (hereinafter called DVHA or the State) is soliciting competitive sealed bids from qualified Vendors for fixed price proposals (Proposals) for Independent Verification and Validation (IV&V) for the Design, Development, and Implementation of a Medicaid Management Information System and Integrated Contact Center System and Services, Pharmacy Benefits Management and Care Management.

This Request for Proposal (RFP) provides details on what is required to submit a Proposal for the Work, how the State will evaluate the Proposals, and what will be required of the Contractor performing the Work.

If a suitable offer is made in response to this Request for Proposal (RFP), the State may enter into a contract (the Contract) to have one or more selected Vendors ("bidders" or "Vendors") perform all or part of the Work.

1.2 Sole point of contact

All communications concerning this RFP will contain the Name and RFP Number in the subject line and must be addressed in writing to the attention of:

Michelle A. Mosher, Procurement Manager

Department of Vermont Health Access (DVHA)

312 Hurricane Lane, Suite 201

Williston, VT 05495-2087

Michelle.Mosher@state.vt.us

(802) 878-7957

Michelle A. Mosher, Procurement Manager is the sole contact for this RFP. Contact with any other State personnel or attempts by bidding Vendors to contact any other State personnel may result in the rejection of their Proposal.

1.3 Procurement Schedule

The following Table 1 documents the critical pre-award events for the procurement and anticipated Contract start date. All dates are subject to change at State of Vermont's discretion.

Table 1. Procurement Schedule

PROCUREMENT SCHEDULE	
RFP Release Date	August 22, 2014
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1.4 Letter of Intent to Bid – Preferred

In order to ensure all necessary communication with the appropriate proposing Vendors and to prepare for the review of proposals, one letter of intent to bid for the scope of this RFP is requested per Vendor.

The Vendor must use the Letter of Intent to Bid provided in Template L. In that Template, the Vendor must specify which of the components of the RFP they intend to respond to.

Letters of Intent must be submitted before or on **August 29th, 2014 by 4:30 pm EST** to:

Michelle A. Mosher, Procurement Manager
Department of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, VT 05495

Or by email at:

Michelle.Mosher@state.vt.us

1.5 State of Vermont Overview

1.5.1 State of Vermont Health System

Spanning more than 9,600 square miles, and home to some 630,000 residents, the State of Vermont is the second least populous state in the country. The State comprises 14 hospitals, 800 primary care providers (PCPs) located in 300 practices and located in 13 hospital service areas. Most PCPs participate in all plans and the health care providers have a strong history of working together.

In addition, Vermont has 11 Federally Qualified Health Centers (FQHCs) with multiple sites serving over 122,000 clients, nearly 20 percent of the state's population. The hospitals and FQHCs together employ more than two-thirds of the physicians in the state. Vermont is very fortunate to have strong community based organizations providing long-term services and supports and that have garnered national reputations for high performance and outcomes. These networks include 11 designated agencies that provide specialized mental health and substance abuse treatment services, and 5 specialized service agencies that provide developmental services. Other long term support services are provided by 112 residential care homes, 40 nursing homes, 12 home health agencies, five area agencies on aging, 14 adult day providers operating in 16 sites, traumatic brain injury providers and more than 7,500 direct care workers. In addition, Support and Services at Home (SASH) is a partnership led by housing providers that connects affordable housing with health and long term services and supports systems, providing targeted support and services at 112 sites to help participants remain safely at home.

There are 17 developmental services and mental health agencies, 12 home health providers, over 90 enhanced residential or nursing facility providers involved delivering a continuum of long term services and supports, 5 substance abuse specialty agencies , family agencies, health promotion, school based and residential treatment programs. The three major health insurance carriers in the State plus Medicaid and Medicare, provide funding for health care services in Vermont.

1.5.2 Vermont Health Care Reform

Vermont has a long history of health care reform, beginning in the 1970s with the expansion of Medicaid to cover children and pregnant women. Most recently, Vermont implemented a state-based health insurance exchange, called Vermont Health Connect, pursuant to the Federal Affordable Care Act and enacted legislation creating Green Mountain Care, a new universal, publicly-financed coverage program for all Vermont residents. The most recent coverage legislation is found in 33 V.S.A. chapter 18, subchapters 1 and 2 (or Act 48 of 2011). More information can be found at: http://hcr.vermont.gov

1.5.3 Act 48 – The Vermont Health Reform Law Of 2011

Act 48 is the key enabling legislation for a universal health system in Vermont. The Act specifically:

- Establishes the Green Mountain Care Board, charged with regulating health insurers and health care providers, to move away from a fee-for-service (FFS) system and control growth in health care costs. The Green Mountain Care Board is responsible to:
  - Improve the health of Vermonters;
  - Oversee a new health system designed to improve quality while reducing the rate of growth in costs;
  - Regulate hospital budgets and major capital expenditures as well as health insurance rates;
  - Approve plans for health insurance benefits in Vermont's new "exchange" program,
  - Approve the Workforce Strategic plan and the HIT plan, both of which are developed by the executive branch and are proposed by AOA, and
- Establishes a Health Benefit Exchange as required by federal law.

The Act outlines the policy choices and supporting technologies that are needed to migrate from the current state of business to the future, universal coverage system to ensure that all Vermonters have health coverage.

1.5.4 Act 171 - An Act Relating to Health Care Reform Implementation

Act 171 is the enabling legislation for Vermont Health Connect, the State's Health Insurance Marketplace. With the establishment of the Marketplace, the State was able to procure and begin to implement the beginnings of the HSE technology and processes, including eligibility determination for Qualified Health Plans and Modified Adjusted Gross Income (MAGI) Medicaid. Additional technologies and services have the potential for reuse or integration for this MMIS procurement.

1.5.5 AHS' Mission, Structure and Public Medicaid Managed Care Model

AHS is the Agency responsible for health care and human services support across the State and has the statutory responsibility for child welfare and protection, the protection of vulnerable populations, public safety, public health, public benefits, mental health and administration of Vermont's public health insurance system. In addition, the AHS serves as the single State Medicaid Agency (SMA).

The State has had a public managed care structure since 2005 and is currently proposing to consolidate long term services and supports and CHIP into the Medicaid Managed Care regulatory framework. Currently Vermont's entire Medicaid program operates under the Global Commitment (GC) to Health Demonstration, with the exception of Long Term Care, DSH and CHIP. The GC Demonstration operates under a managed care model that is designed to provide flexibility with regard to the financing and delivery of health care in order to promote access, improve quality and control program costs. AHS, as Vermont's SMA, is responsible for oversight of the managed care model. DVHA is the entity delegated to operate the managed care model and has sub-agreements with the other State entities that provide specialty care for GC enrollees (e.g., mental health services, developmental disability services, school health services, and early childhood services).

In addition to state plan Medicaid services and eligibility groups, Vermont has CMS authorization to administer several "Designated State Health Programs" (DSHP) and to provide an expanded array of Medicaid reimbursement services that do not appear in the state plan. The MMIS must be able to track all AHS/CMS approved services and supports to comply with federal CMS reporting as described in the Special Terms and Conditions of the State's 1115 demonstration and its associated Waiver and Expenditure authority documents.

Payments are not limited to those methodologies described in the Medicaid State Plan. As a public MCO, DVHA and its AHS partners have employed sub-capitated, pay for performance, case rate and other bundled rate payment methodologies for Medicaid State Plan and other specialty programs. The MMIS must be capable of tracking, reporting and disbursing payments outside of a fee for service environment.

As an MCO, the State has authority to invest in programs that will enhance quality and access to services and promote health outcomes. MCO investment payments may be made outside of the MMIS, but will need to be brought together with MMIS information for federal reporting to CMS.

AHS consists of the following Departments with the following responsibilities:

- **Department for Children and Families (DCF)** — DCF provides a wide array of programs and services, including adoption and foster care, child care, child development, child protection, child support, disability determination, and economic benefits such as: Reach Up, Essential Person, General Assistance/Emergency Assistance, 3SquaresVT, Home Heating Assistance and Health Insurance.

- **Vermont Department of Health (VDH)** — VDH sets the State's public health priorities and works with the State to help realize public health goals within the population served by the State. VDH collaborates with the State on clinical initiatives to reduce medical costs in the State through the agency's GC program waiver. These programs include

Early Periodic Screening, Diagnosis, and Treatment (EPSDT) and dental care initiatives to children across the State.

- **Department of Corrections (DOC)** — DOC is responsible for managing all adult prisons and community correctional sites. For incarcerated offenders, the department is required and committed to providing basic and humane care that includes comprehensive integrated health and mental health services that are connected with and continue as the individual transitions from or into the community. For offenders in the community, the department is charged with ensuring compliance with conditions by providing or coordinating a variety of support services. The State maintains a unified correctional system with 8 correctional (prison/jails/work-camps) facilities spread out over the State. Each facility provides comprehensive health and mental health services to 8,000+ Vermonters over the course of a year. The majority of offenders entering and leaving corrections are Medicaid eligible.

- **Department of Disabilities, Aging and Independent Living (DAIL)** — DAIL administers all community-based long-term care services for older Vermonters, individuals with developmental disabilities, traumatic brain injuries, physical disabilities, personal care/attendant services, high technology nursing, and the Choices for Care Long Term Care Medicaid Waiver program.

- **Department of Mental Health (DMH)** — DMH is responsible for administering mental health services and programs for children and adults across the State. DMH assures access to mental health services and works closely with multiple human service agencies to coordinate care. The department's work includes designation and collaborative oversight for community-based mental health care and a decentralized, statewide system of inpatient care.

- **Department of Vermont Health Access (DVHA)** — DVHA administers nearly all of the publicly funded health care programs for the State of Vermont. Funding of these programs is provided through Medicaid and is authorized under two (2) CMS approved 1115 Demonstration waivers and includes information technology enhancements, Disproportionate Share Hospital (DSH) payments, and the State Children's Health Insurance Program (SCHIP) services. In addition, DVHA administers the State's health care reform efforts including health information technology (HIT) and health information exchange (HIE) activities, and Blueprint.

The AHS Organization Chart can be found in the Procurement Library. In addition to the departments listed above, AHS coordinates closely with the Agency of Education and has long standing interagency agreements related to the use of Medicaid to support EPSDT outreach, school-based health services, early childhood development, mental health, and health promotion.

1.5.6 Agency of One

The "Agency of One" is the approach within the Agency of Human Services that enables our state staff working together with an integration focus to deliver effective client centered experiences. This is discussed in AHS' strategic plan at: http://humanservices.vermont.gov/strategic-plan/ahs-strategic-plan/ahs-strategic-plan/view.

The goals of this approach include:

- **Decrease the lasting impacts of poverty** on individuals, children and families in Vermont and create pathways out of poverty
- **Promote the health, well-being and safety** of individuals, families and our communities
- Enhance AHS's focus on **program effectiveness, accountability** for outcomes, and **workforce development and engagement**
- Ensure that all Vermonters have **access to high quality health care**

The State understands this:

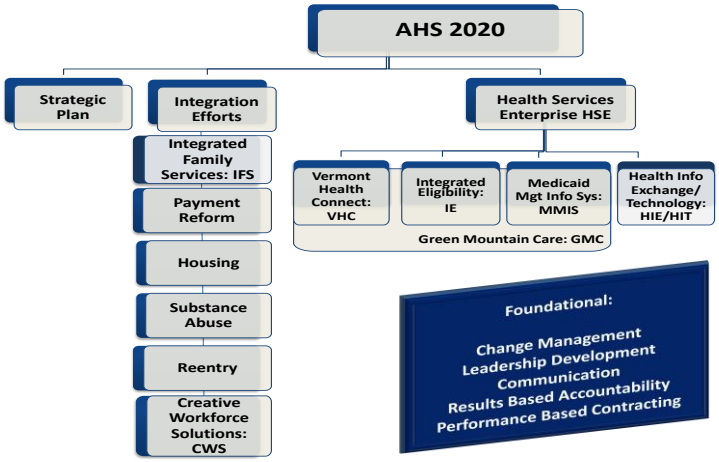
- Requires Accountability: Results Based Accountability
- Emphasizes root causes, prevention & early intervention, not just symptoms
- Involves multiple organizations: AHS, State Government, Community Partners

1.6 Health and Human Services Enterprise Overview

The Agency of Human Services (AHS) Health and Human Services Enterprise (HSE) Program is a multi-year, multi-faceted program that provides for planning and strategy, change management and project execution in support of Vermont's next generation of health and human services capabilities, including Green Mountain Care, the publicly financed, universal coverage program envisioned by Governor Shumlin.

The "Enterprise" (i.e., agency-wide) approach supports AHS integration and outcome initiatives such as Integrated Family Services (IFS), Housing, Substance Abuse, Reentry, Payment Reform, Creative Work Solutions, Results-based Accountability, and Performance-based Contracting; and aligns with the AHS Strategic Plan to achieve results in the following areas: 1) reduction of the lasting impacts of poverty, 2) promotion of community health, wellbeing and safety, 3) enhancement of program effectiveness and accountability, and 4) health system reform.

Figure 1. Agency of Human Services Health and Human Services Enterprise Overview



The foundation of the HSE Program is a person-/family-centric, integrated service delivery model enabled by information technology (IT) projects:

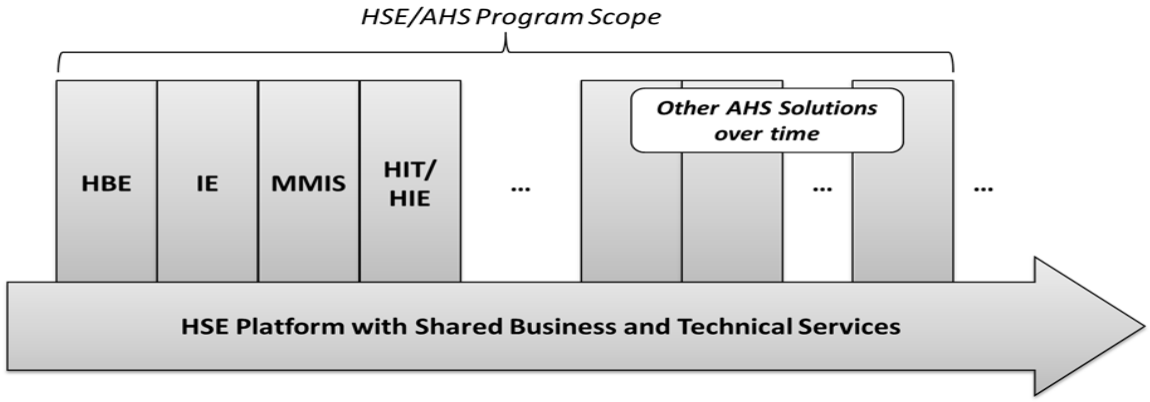
Vermont Health Connect (VHC) offers online access to both private and public health care coverage. VHC went live on October 1, 2013.

Integrated Eligibility (IE) means "real-time" screening, application and eligibility determination. An IE Request for Proposal (RFP) has been released. Health care programs are expected to go live in IE at the end of 2015 while the non-health care programs follow beginning in 2016.

Medicaid Management Information System (MMIS) includes a Pharmacy Benefits Manager (PBM) component (expected go-live in early 2015), a Care Management component (expected go-live during 2015), and the Core operations claims engine (expected go-live date in early 2017).

Health Information Exchange/Technology (HIE/HIT) will be the successful transmission of accurate, up-to-date clinical data among healthcare providers. By improving provider and patient access to clinical data and data sets, HIE will lower the growth in healthcare costs and provide better health-related outcomes.

Figure 2. HSE/AHS Program Scope



The HSE Program is administered by AHS in partnership with the Agency of Administration (AOA) including the Director of Health Care Reform, Department for Information and Innovation (DII) and the Department of Finance and Management. The Governance Structure includes an Executive Steering Committee, an Operations Steering Committee, and Project and Process Teams.

1.6.1 Current Related Initiatives

Integrated investment in functional solutions and a standard computing platform is a key enabler for the State to adopt an enterprise approach, and achieve true innovation in health care for the general population. All listed initiatives will have impacts on the scope and functionality needed for the MMIS. Relevant initiatives are listed in the table below.

Table 2. Agency of Human Services' Health and Human Services Enterprise Initiatives

INITIATIVE	DESCRIPTION
Health and Human Services Enterprise (HSE) Platform	The HSE Platform is envisioned as a suite of shared services that are reusable across solutions. Additional details on the Platform are provided below.
Integrated Eligibility (IE)	The ACCESS System is currently the "system of record" for Medicaid, 3SquaresVT, General Assistance, Reach Up and LIHEAP in the state of Vermont. This legacy system is slated for replacement. The state of Vermont is in the procurement process for a new eligibility system, referred to as the "Integrated Eligibility" System.and The Integrated Eligibility System is expected to provide eligibility processing for the

INITIATIVE	DESCRIPTION
	State's health and human services programs.
Vermont Health Connect (VHC)	The State elected to establish a State-run Health Insurance Marketplace, named Vermont Health Connect (VHC). The initiative provides eligibility determination for Medicaid (based on Modified Adjusted Gross Income MAGI) and the Children's Health Insurance Program (CHIP), Qualified Health Plan, and additional services for non-Medicaid Marketplace activities. VHC passes all Medicaid eligibility determinations to ACCESS (IE) for use by the MMIS. Upon retirement of the ACCESS (IE) legacy system, VHC will pass these determinations to the new integrated eligibility solution.
Green Mountain Care 2017	As part of Act 48, Vermont is preparing to move to a universal, publicly-financed health coverage system in 2017. This approach will ensure that all Vermonters will have coverage based on residency, not based on their employer or employment status. Additional details can be found in other sections of this RFP
Vermont Information Technology Leaders (VITL)	A non-profit organization, VITL is the State's Regional Health Information Organization (RHIO). It is in the process of establishing the State's health information exchange network and is charged with the development of Vermont's Health Information Technology Plan. VITL has connected almost all of Vermont's 14 hospitals to the Vermont Health Information Exchange. There are more than 60 Vermont physician practices participating in the exchange, receiving and sending data. The State is an active participant in VITL efforts and the creation of the State plan. Information on the statute authorizing VITL, its organization, and its activities can be found at: http://vitl.net

1.6.2 Enterprise Project Management Office (EPMO)

The EPMO is part of the Vermont Department of Information and Innovation. It is an internal service organization for Vermont state government created in 2006 by the Vermont State Legislature. The mission of the EPMO is to support the State of Vermont in the pursuit of technology that aligns with the State's Information Technology Strategic Plan and results in the completion of on-time, in-scope, and on-budget technology projects.

The goal of the EPMO is to establish repeatable project management processes (consistent with industry standards and best practices); offer project management guidance and training; perform project oversight (as required by state statute); and provide useful tools, templates and information that will contribute to project success.

1.6.3 Health and Human Services Program Management Office

The State has established a Program Management Office (PMO) that consists of representation from the Governor's direct staff through the Agency of Administration down to the Agency of Human Services (AHS) Secretary and multiple Departments within the AHS. The PMO is the 'hub' from which the various work-streams are governed and it operates under the guidance and support of the Executive Steering Committee (ESC).

1.6.4 MMIS Project Overview

The MMIS project is a core element of the AHS Health and Human Services Enterprise (HSE) vision. The MMIS project will align Vermont's Medicaid Management Information System with new Federal and State regulations stemming from the Federal Affordable Care Act and Vermont's Heath Care vision, Act 48. Vermont has undertaken an aggressive program to overhaul health care; dramatically changing health care facilitation, funding, and processes. The current system relies on data that is inefficiently stored and retrieved and is unable to establish a member-centric view across the range of services provided by the state. This lack of interoperability fosters a silo approach to Medicaid program and member care management at the department level. Shortcomings in data management create limitations to DVHA staff when it comes to detecting and remediating Fraud, Waste, and Abuse.

The new MMIS will integrate Service Oriented Architecture (SOA), creating a configurable, interoperable system, and be compliant with Center for Medicare and Medicaid Services (CMS) Seven Standards and Conditions. It will utilize the strategic HSE Platform as a means of integration to other HSE components and service and align with MITA 3.0 business processes.

The vision of Vermont's MMIS can be pictured as a contemporary SOA based system that efficiently and securely shares appropriate data with Vermont's Agencies, Providers and other stakeholders involved in a member's care.

AHS will serve Vermonters more effectively within the new framework that will benefit the state through improved efficiency and processes while reducing costs. The overarching goal is two-fold; to reduce total health care costs to Vermont taxpayers while improving health care outcomes through improved systems and processes.

1.7 Contract Information

1.7.1 All contract and legal requirements are found in Template M — Terms & Conditions of this RFP and Any Resulting Contract.

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2.0 General Instruction and Proposal Requirements

2.1 Questions and Comments

Any Vendor requiring clarification of any section of this proposal or wishing to comment or take exception to any requirements or other portion of the RFP must submit specific questions in writing no later than **4:30 PM EST on September 4th, 2014**. Questions may be e-mailed to Michelle.Mosher@state.vt.us. No questions will be accepted via telephone. Any objection to the RFP or to any provision of the RFP, that is not raised in writing on or before the last day of the question period is waived. Every effort will be made to have the State's responses posted by **September 10th, 2014**, contingent on the number and complexity of the questions. A copy of all questions or comments and the State's responses will be posted on the State's website:

2.2 Letter of Intent to Bid - Preferred

Vendors are requested to submit a Letter of Intent to Bid but not required.

The Vendor must use the Letter of Intent to Bid provided in Template P. In that Template, the Vendor must specify which of the components of the RFP they intend to respond to.

Letters of Intent must be submitted by **August 29, 2014 by 4:30 PM EST** to:

Michelle A. Mosher, Procurement Manager
Department of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, VT 05495

Or by email to:

Michelle.Mosher@state.vt.us

2.3 Modification or Withdrawal of Proposal

Prior to the proposal submission deadline set forth in Section 1.3, a Vendor may: (1) withdraw its Proposal by submitting a written request to the State point of contact, or (2) modify its Proposal by submitting a written amendment to the State point of contact. The State may request proposal modifications at any time.

The State reserves the right to waive minor informalities in a proposal and award a contract that is in the best interest of the State of Vermont. A "minor informality" is an omission or error that, in DVHA's determination, if waived or modified when evaluating proposals, would not give a Vendor an unfair advantage over other Vendors or result in a material change in the proposal

or RFP requirements. When DVHA determines that a proposal contains a minor informality, it may at its discretion provide the Vendor with the opportunity to correct.

2.4 News Releases

Prior to tentative award, a Vendor may not issue a press release or provide any information for public consumption regarding its participation in the procurement. After tentative award, a Vendor must receive prior written approval from the State before issuing a press release or providing information for public consumption regarding its participation in the procurement. Requests should be directed to the State point of contact identified in Section 1.

This does not preclude business communications necessary for a Vendor to develop a Proposal, or required reporting to shareholders or governmental authorities.

2.5 Multiple Responses

The Vendor may only submit one (1) Proposal as a prime Vendor. If the Vendor submits more than one (1) proposal as a prime, the State may reject one or more of the submissions. This requirement does not limit a Vendor's ability to collaborate with one or more Vendors as a Subcontractor submitting proposals.

2.6 Amendments and Announcements Regarding this RFP

The State will post all official communication regarding this RFP on its website (http://www.vermontbidsystem.com), including any notice of tentative award. The State reserves the right to revise the RFP at any time. Any changes, amendments, or clarifications will be made in the form of written responses to Vendor questions, amendments, or addenda issued by the State on its website. Vendors should check the website frequently for notice of matters affecting the RFP.

Additionally, in order to keep potential QA/IV&V Vendors well-informed the State will issue all Addendums to the DVHA RFP website (http://dvha.vermont.gov/administration/2013-requests-for-proposals) when additional information becomes available pertaining to the Medicaid Management Information System (MMIS) and other relevant procurements.

Any contract resulting from this RFP will be between the State of Vermont and the selected Vendor. Any requirements specified herein post award are specifically by and between the State of Vermont and the selected Vendor.

2.7 Use of Subcontractors

Subject to the conditions listed in this RFP, the Vendor may propose to use a Subcontractor(s) to make a complete offer to perform all services. Any prospective Subcontractor that is not a wholly owned subsidiary of the Vendor will be subject to these conditions.

The conditions for proposing to use Subcontractors include, but are not limited to, the following:

1. Prior to any communication or distribution of State confidential information to the potential Subcontractor, the Vendor must provide the State with the name of the potential Subcontractor in advance and in writing. The Vendor will provide contact information for the potential Subcontractor.

    a. The State must give its written approval prior to the Vendor providing any State confidential information to a potential Subcontractor or another entity.

2. If selected, the Vendor will be the prime Vendor for services provided to the State by approved Subcontractors.

3. The Vendor will be ultimately responsible for the provision of all services, including Subcontractor's compliance with the service levels, if any.

4. Any Subcontractor's cost will be included within the Vendor's pricing and invoicing.

No subcontract under the Contract must relieve the Vendor of the responsibility for ensuring the requested services are provided. Vendors planning to subcontract all or a portion of the Work to be performed must identify the proposed Subcontractors.

2.8 Interpretive Conventions

Whenever the terms "must," "shall," "will" or "is required" are used in this RFP in conjunction with a specification or performance requirement, the specification or requirement is mandatory. A Vendor's failure to address or meet any mandatory requirement in a proposal may be cause for the State's rejection of the Proposal.

Whenever the terms "can," "may," or "should" are used in this RFP in conjunction with a specification or performance requirement, the specification or performance requirement is a desirable, but not mandatory, requirement. Accordingly, a Vendor's failure to address or provide any items so referred to will not be the cause for rejection of the Proposal, but will likely result in a less favorable evaluation.

2.9 Instructions for Submitting Proposals

2.9.1 Number of Copies

The Vendor is required to submit one (1) clearly marked original Proposal and seven (7) identical copies of the complete Proposal, including all sections and exhibits, in three-ring binders, and one (1) electronic copy on a portable medium such as a compact disk.

The bid should include a Technical Response and a separate Cost Response. The State will not accept electronic and facsimile proposals. Any disparities between the contents of the original printed Proposal and the electronic Proposal will be interpreted in favor of the State.

2.9.2 Submission

All bids must be sealed and addressed to:

Department of Vermont Health Access (DVHA)
Michelle A. Mosher, Procurement Manager
312 Hurricane Lane. Suite 201
Williston, VT 05495-2087
Michelle.Mosher@state.vt.us

BID ENVELOPES MUST BE CLEARLY MARKED 'SEALED BID' AND SHOW THE REQUISITION NUMBER AND/OR PROPOSAL TITLE, OPENING DATE AND NAME OF VENDOR.

All Vendors are hereby notified that sealed bids must be received and time stamped by DVHA Business Office located at 312 Hurricane Lane, Suite 201, Williston, VT 05495 by **1:00 PM EST on October 2nd, 2014**. Bids not in possession of the Office of Purchasing & Contracting at the time of the bid opening will be returned to the Vendor, and will not be considered.

Office of Purchasing & Contracting may, for cause, change the date and/or time of bid openings or issue an addendum. If a change is made, the State will make a reasonable effort to inform all Vendors by posting at: http://www.vermontbidsystem.com

The bid opening will be held at **1:15 PM EST on October 2nd, 2014** at 312 Hurricane Lane, Suite 201 Williston, VT 05495 and is open to the public. Typically, the State will open the bid and read the name and address of the Vendor. Bid openings are open to members of the public. However no further information which pertains to the bid will be available at that time other than the bid amount, name and address of the Vendor. The State reserves the right to limit the information disclosed at the bid opening to the name and address of the Vendor when, in its sole discretion, it is determined that the nature, type, or size of the bid is such that the State cannot immediately (at the opening) establish that the bids are in compliance with the RFP. As such, there will be cases in which the bid amount will not be read at the bid opening. Bid results are a

public record. However, the bid results are exempt from disclosure to the public until the award has been made and the Contract is executed with the apparently successful Vendor.

2.9.2.1 Delivery Methods

U.S. MAIL: Vendors are cautioned that it is their responsibility to originate the mailing of bids in sufficient time to ensure bids are received and time stamped by the DVHA Business Office prior to the time of the bid opening.

EXPRESS DELIVERY: If bids are being sent via an express delivery service, be certain that the RFP designation is clearly shown on the outside of the delivery envelope or box. Express delivery packages will not be considered received by the State until the express delivery package has been received and time stamped by the DVHA Business Office.

HAND DELIVERY: Hand carried bids shall be delivered to the Procurement Officer or their designee prior to the bid opening.

ELECTRONIC: Electronic bids will not be accepted.

FAXED BIDS: Faxed bids will not be accepted.

2.9.2.2 Proposal Submission Requirements

Vendors must strictly adhere to the following response submission requirements:

1. Failure to follow any instruction within this RFP may, at the State's sole discretion, result in the disqualification of the Vendor's Proposal.
2. The State has no obligation to locate or acknowledge any information in the Vendor's Proposal that is not presented under the appropriate outline according to these instructions and in the proper location.
3. The Vendor's Proposal must be received, in writing, at the address specified in this RFP, by the date and time specified. The State WILL NOT BE RESPONSIBLE FOR DELAYS IN THE DELIVERY OF QUESTION DOCUMENTS. Any Proposal received after proposal opening time will be returned unopened.
4. Proposals or alterations by fax, e-mail, or phone will not be accepted.
5. Original signatures are required on one (1) copy of the Submission Cover Sheet and Template M, and Vendor's original submission must be clearly identified as the original.
6. The State reserves the right to reject any proposals, including those with exceptions, prior to and at any time during negotiations.

7. The State reserves the right to waive any defect or irregularity in any proposal procedure.

8. The Vendor must not alter or rekey any of the original text of this RFP. If the State determines that the Vendor has altered any language in the original RFP, the State may, in its sole discretion, disqualify the Vendor from further consideration. The RFP issued by the State of Vermont is the official version and will supersede any conflicting RFP language submitted by the Vendor.

9. To prevent opening by unauthorized individuals, all copies of the Proposal must be sealed in the package. A label containing the information on the cover page must be clearly typed and affixed to the package in a clearly visible location.

10. The Vendor acknowledges having read and accepted all sections by signing the Template A and M.

It is the responsibility of the Vendor to clearly identify all costs associated with any item or series of items in this RFP. The Vendor must include and complete all parts of the Cost Proposal in a clear and accurate manner. Omissions, errors, misrepresentations, or inadequate details in the Vendor's Cost Proposal may be grounds for rejection of the Vendor's Proposal. Costs that are not clearly identified will be borne by the Vendor.

2.9.3 Additional Information or Clarification

The State reserves the right to request additional information or clarification of a Vendor's Proposal. The Vendor's cooperation during the evaluation process in providing State staff with adequate responses to requests for clarification will be considered a factor in the evaluation of the Vendor's overall responsiveness. Lack of such cooperation may, at the State' discretion, result in the disqualification of the Vendor's Proposal.

1. Vendors may request additional information or clarifications to this RFP using the following procedures:

   a. Vendors must clearly identify the specified paragraph(s) in the RFP that is/are in question.

   b. Vendors must deliver a written document to the sole point of contact as identified in Section 1.2 of this RFP.

   c. This document may be delivered by hand, via mail or e-mail, The State WILL NOT BE RESPONSIBLE FOR DELAYS IN THE DELIVERY OF QUESTION DOCUMENTS.

   d. It is solely the responsibility of the Vendor that the clarification document reaches the State on time. Vendors may contact the sole point of contact to verify the

receipt of their documents. Documents received after the deadline will be rejected. All questions will be compiled and answered and a written document containing all questions submitted and corresponding answers will be posted on the State's website (http://www.vermontbidsystem.com).

Unsolicited clarifications and updates submitted after the deadline for responses will be accepted or rejected at the sole discretion of the State.

2.10 Proposal Instructions

Proposals must address all the requirements of the RFP in the order and format specified in this section. Each RFP requirement response in the Proposal must reference the unique identifier for the requirement in the RFP.

It is the Vendor's responsibility to ensure its Proposal is submitted in a manner that enables the Evaluation Team to easily locate all response descriptions and exhibits for each requirement of this RFP. Page numbers should be located in the same page position throughout the Proposal. Figures, tables, charts, etc. should be assigned index numbers and should be referenced by these numbers in the Proposal text and in the Proposal Table of Contents. Figures, tables, charts, etc. should be placed as close to text references as possible.

Unless otherwise specified, Proposals shall be on 8-1/2" x 11" white bond paper with no less than ½" margins and eleven (11) point fonts. Pages shall be consecutively numbered within the bottom or top margin of each page, including attachments, such that if the document became separated, it could easily be put back together. Hard copy proposals are to be assembled in loose-leaf, three-hole punch binders with appropriate tabs for each volume and section. Do not provide proposals in glue-bound binders or use binding methods that make the binder difficult to remove.

At a minimum, the following should be shown on each page of the Proposal:

1. RFP #
2. Name of Vendor
3. Page number

2.10.1 Proposal Format

The Proposal must be structured in the following manner and must consist of all the sections, separated into two (2) packages as described below.

- ***Package 1 - Technical Proposal***

This package of the Vendor's response must include Sections A through M as described below. Each section corresponds to the **Response Template** designated with the same letter.

Section A. Cover Letter and Executive Summary

This section of the Vendor's Technical Proposal must include a cover letter and executive summary stating the Vendor's intent to bid for this RFP.

The Vendor's response must include a transmittal (cover) letter; table of contents; executive summary; Vendor contact information and locations.

Submission for this section must be compliant with the instructions detailed in Response Template A – Cover Letter and Executive Summary.

Section B. Vendor Experience

This section of the Vendor's Technical Proposal must include details of the Vendor's Experience.

The Vendor's response must include Vendor organization overview; corporate background; Vendor's understanding of the HHS domain; and Vendor's experience in public sector.

Submission for this section must be compliant with the instructions detailed in Response Template B - Vendor Experience.

Section C. Vendor References

This section of the Vendor's Technical Proposal must include Vendor's References.

The Vendor's response must include at least three (3) references from projects performed within the last five (5) years that demonstrate the Vendor's ability to perform the Scope of Work described in the RFP. If the Proposal includes the use of Subcontractor(s), provide three (3) references for each.

Submission for this section must be compliant with the instructions detailed in Response Template C – Vendor References.

Section D. Subcontractor Letters

This section of the Vendor's Technical Proposal must include a letter of the Vendor's proposed Subcontractor(s) that will be associated with this Contract.

Submission for this section must be compliant with the instructions detailed in the Response Template D – Subcontractor Letters.

Section E. Vendor Organization and Staffing

This section of the Vendor's Technical Proposal must include a narrative of the Vendor's proposed Organization and Staffing approach to meet the State's System requirements.

The Vendor's response must include the proposed approach to: organization plan; organization chart; key staff; Subcontractors; staff contingency plan; staff management plan; staff retention and the Vendor's approach to working with the Medicaid Projects staff.

Submission for this section must be compliant with the instructions detailed in the Response Template E – Vendor Project Organization and Staffing.

Section F. Staff Experience

This section of the Vendor's Technical Proposal must include a narrative of the Vendor's Staff Experience.

The Vendor's response must include the proposed approach to: roles and responsibilities; summary of skill sets; total years of experience in the proposed role; qualifications and resumes.

Submission for this section must be compliant with the instructions detailed in Response Template F – Staff Experience.

Section G. Requirements

This section of the Vendor's Technical Proposal must include a response to the Requirements provided in Response Template G –Requirements. The objective of the Template response is to provide the State team with a structured response that will allow them to understand the degree to which each Vendor's approach has the potential of meeting the State Project requirements.

The 'Response Columns' within each tab of the Requirements matrix must be completed by the Vendor as described in the instructions detailed in Response Template G –Requirements.

Section H. High-Level QA/IV&V Plan

This section of the Vendor's Technical Proposal must include narrative of the Vendor's proposed High-Level QA/IV&V Plan. In response to Response Template H –High-Level QA/IV&V Plan, the Vendor must provide a narrative overview of how their proposed services will meet the State's requirements. The Vendor must complete this response section as a part of its response.

Submission for this section must be compliant with the instructions detailed in Response Template H –High-Level QA/IV&V Plan.

Section I. Work Plan

This section of the Vendor's Technical Proposal must include a Work Plan that will be used to create a consistent and coherent management plan. This Work Plan will demonstrate that the Vendor has a thorough understanding for the Scope of Work and what must be done to satisfy the project requirements. Submission for this section must be compliant with the instructions detailed in Response Template I – Work Plan.

The Work Plan must include detail sufficient to give the State an understanding of how the Vendor's knowledge and approach will:

- Manage the Work;
- Guide Work execution;
- Document planning assumptions and decisions;
- Facilitate communication among stakeholders; and
- Define key management review as to content, scope, and schedule.

Section J. RFP Response Checklist and Supplements

This section of the Vendor's Technical Proposal must include the completed checklist verifying that all the RFP response requirements as part of Templates A through I and the RFP Attachments have been completed. Submission for the Proposal Checklist and Supplements must be compliant with the instructions detailed in Response Template J – RFP Response Checklist.

Section M. Terms & Conditions of this RFP and Any Resulting Contract

This section of the Vendor's Technical Proposal must include the completed signed legal and contracting requirements. The vendor must sign and review Template M – Terms & Conditions of this RFP and Any Resulting Contract in order to note Vendor's acknowledgement, intent of compliance, and/or exceptions to the following: (1) RFP Terms & Conditions; (2) Mandatory Contract Terms; (3) Standard State Provision for Contracts and Grants; and (4) General Terms & Conditions.

- ***Package 2 - Cost Proposal***

This package of the Vendor's response must include Response Template K – Cost Workbook as described below.

Section K. Cost Proposal Instructions

The Cost Proposal must include a response through the submission of Response Template K – Cost Workbook. Vendors must complete this workbook as instructed and place it in a separate, sealed package, clearly marked as the Cost Proposal with the Vendor's name, the RFP number, and the RFP submission date.

Vendors must base their Cost Proposals on the Scope of Work described in Section 2.0 and associated sections of this RFP and Templates. The Cost Proposals must include any business, economic, legal, programmatic, or practical assumptions that underlie the Cost Proposal. The State reserves the right to accept or reject any assumptions. All assumptions not expressly identified and incorporated into the Contract resulting from this RFP are deemed rejected by the State.

Vendors are responsible for entering cost data in the format prescribed by Response Template K - Cost Workbook. Formulas have been inserted in the appropriate cells of the worksheets to automatically calculate summary numbers, and should not be altered. Further instructions for entering cost data are included in the worksheets. It is the sole responsibility of the Vendor to ensure that all mathematical calculations are correct and that the Total Costs reflect the Bid Amount(s) for responses to this RFP, or portions thereof.

Completion of the Cost Workbook and worksheets is mandatory. Applicable purchase, delivery, tax, services, safety, license, travel, per diem, Vendor's staff training, Project facility, and any other expenses associated with the delivery and implementation of the proposed items must be included in the Vendor's costs and fixed Hourly Rates.

The Cost Proposal MUST BE A SEPARATE SUBMISSION. No cost information can be contained in the Technical Proposal submission. If there is cost information in the Technical Proposal, the Vendor can be disqualified from consideration.

2.10.2 Proposal Crosswalk — Mandatory Templates

The table below lists the Mandatory templates that the Vendor will submit as part of its Technical and Cost Proposal Packages.

Table 3. Mandatory Response Templates

RESPONSE TEMPLATE	TEMPLATE / ATTACHMENT ELEMENTS
Response Template A	Cover Letter and Executive Summary

RESPONSE TEMPLATE	TEMPLATE / ATTACHMENT ELEMENTS
Response Template B	Vendor Experience
Response Template C	Vendor References
Response Template D	Subcontractor Letters
Response Template E	Project Organization and Staffing
Response Template F	Staff Experience
Response Template G	Requirements
Response Template H	High Level QA/IV&V Plan
Response Template I	Work Plan
Response Template J	RFP Response Checklist & Supplements
Response Template K	Cost Workbook
Response Template M	Terms & Conditions of this RFP and Any Resulting Contract

2.11 Order of Precedence

In the event of any conflict or contradiction between or among these documents, the documents shall control in the following order of precedence:

- The final executed Agreement, attachments, AHS General Provisions, and all amendments thereto;
- The RFP, as clarified by amendments, the Vendor questions and the State's official responses thereto; and
- Vendor's Proposal to this RFP.

2.12 Procurement Library

The following table describes the documents that are available in the Procurement Library for reference purposes.

Table 4. Procurement Library

FILE #	PROCUREMENT LIBRARY ITEM FILE NAME
1	Medicaid Management Information System Design, Development, and Implementation, Medicaid Operations Services, and Integrated Contact Center System RFP http://dvha.vermont.gov/administration/7mmis-information-technology-rfp.pdf
2	Care Management RFP http://dvha.vermont.gov/administration/2vermont-care-management-rfp.pdf
3	Pharmacy Benefit Management RFP http://dvha.vermont.gov/administration/1vermont-pbm-rfp-final.pdf
4	Integrated Eligibility RFP http://bgs.vermont.gov/purchasing/bids/InformationTechnologyRFPIntegratedEligibilitySolution
5	MMIS Specialized Program Projects (Previously known as HSE/MMIS RFP) http://dvha.vermont.gov/administration/1health-services-enterprise-medicaid-management-rfp-06.30.2014.pdf
6	Vermont Health Connect http://dvha.vermont.gov/administration/contracts
7	Jumbo Advanced Planning Document http://dvha.vermont.gov/administration/health-services-enterprise
8	Food and Nutrition Services Advanced Planning Document http://www.fns.usda.gov/apd/fns-oversight-state-systems-advance-planning-document-process
9	Medicaid Enterprise Certification Toolkit (MECT) http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MMIS/MECT.html
10	AHS Organization Chart http://humanservices.vermont.gov/publications/ahs-organizational-chart

FILE #	PROCUREMENT LIBRARY ITEM FILE NAME
11	AHS Strategic Plan http://humanservices.vermont.gov/strategic-plan/ahs-strategic-plan/ahs-strategic-plan/view
12	DVHA Strategic Plan http://humanservices.vermont.gov/strategic-plan/dvha-strategic-plan/view
13	DII Strategic Plan http://dvha.vermont.gov/administration/vt-dii-strategic-plan-2013-to-2018-.pdf
14	Medicaid State Plan http://dvha.vermont.gov/administration/state-plan
15	Current Provider Portal http://www.vtmedicaid.com/
16	HSE Architecture Diagram http://dvha.vermont.gov/administration/health-services-enterprise-architecture.pdf
17	Enterprise Architecture Principles for the HSE Platform http://bgs.vermont.gov/sites/bgs/files/pdfs/purchasing/VEAF%20Manual%20-%20GUIDEBOOK%205_13_2014.pdf

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3.0 Overview and Scope of Work

3.1 Overview

The State of Vermont is executing a transformational change to their Model of Practice for health and human services to move from a program-centric to a person-centric model. To enact this change, the State has chartered the Health and Human Services Enterprise (HSE) Program to address the people, process and technology components required to make the change a reality. Due to the criticality and complexity of the HSE Program, the State has defined a standardized approach to Quality Assurance (QA)/Independent Verification and Validation (IV&V) services to ensure the success of the HSE Program and each supporting project under the Program.

This section provides an overview of the HSE Program's vision and the projects the State will undertake to achieve the vision. This section provides a description of the coordinated approach to QA/IV&V across the HSE Program and projects and defines the tasks, deliverables and requirements the QA/IV&V Vendor must provide to support the Medicaid Projects (see below for definition of Medicaid Projects), key components of the Program.

Throughout this RFP, the term:

- "Vendor" or "QA/IV&V Vendor" refers to the provider that will perform the QA/IV&V services.
- "DDI Vendor" refers to the system integrator(s) who will design, develop and implement (DDI) the MMIS, Contact Center, Care Management, and Pharmacy Benefit Management solutions.
- "Medicaid Projects" refers to the collection of three DDI procurements (1) Medicaid Management Information System (MMIS), Medicaid Operations Services and Integrated Contact Center System and Services, (2) Care Management System, and (3) Pharmacy Benefits Management System.

3.1.1 The Agency of Human Services (AHS) HSE Program

The Agency of Human Services (AHS) HSE Program is a multi-year, multi-phase approach that reshapes and integrates current health and human services business processes, improves public-private sector partnerships, enhances the utilization of information, modernizes the IT environment, and results in the transformation of the State's health and human services to improve access, outcomes, costs and quality.

Figure 3. AHS Vision Statement

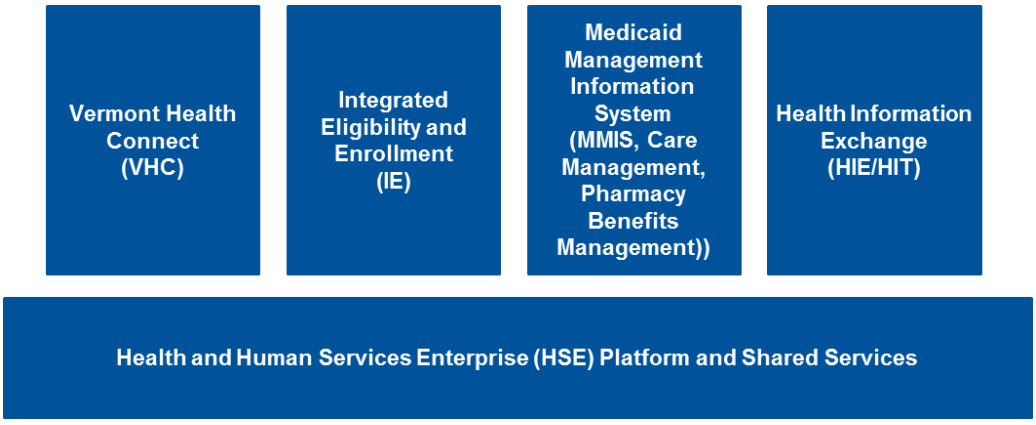
The Agency's Health and Human Services Enterprise (HSE) is Vermont's next generation of coordinated, integrated and more cost-effective health and human services capabilities. Connecting information and promoting collaboration in a service-oriented, person-centric environment will result in improved access to health care and delivery of human services programs available from the state. This in turn will yield better and more cost-effective outcomes for Vermonters. These evolving capabilities will be used to enable the state's emerging strategy for a reformed health care delivery system.

The HSE strategy is to invest in new and upgraded components and technology that serve the current and near-term needs, and form the technical foundation on which the State can continually evolve to an integrated enterprise within a strategic timeframe. At the same time, these components will help the State transition to support Vermont's envisioned public-private universal health care system.

The HSE Program is the comprehensive collection of Health Information Technology (HIT) and Health Reform Information Technology systems. As depicted in Figure 4, five (5) key components of the HSE are the Vermont Health Connect (VHC) online health insurance marketplace, the Integrated Eligibility (IE) solution, the Medicaid Management Information System (MMIS; including an enhanced set of provider and member Contact Center capabilities), the Health Information Exchange (HIE/HIT) and the HSE Platform and Shared Services.

The scope of this RFP includes QA/IV&V services for the Medicaid Projects under the HSE Program.

Figure 4. Health and Human Services Enterprise Overview



3.1.2 AHS Expectations for an Enterprise Approach to HSE Program Governance

A governance structure has been established to support and develop the enterprise vision of the HSE. The HSE Program Management Office (HSE PMO):

- Manages the overall Program
- Manages the interaction between the projects through the Program-level lens
- Establishes consistent processes, tools and artifacts to manage cross-project dependencies, funding, reuse and processes

The governance of the Program represents all stakeholder organizations of the HSE and extends through varying levels of government, including the Governor's Office, Agency of Administration (AOA), Department of Information and Innovation (DII), and the AHS which is the executive sponsor of the HSE Program.

A summary Program organizational chart is shown in Figure 5.

Figure 5. HSE Governance Structure

A key imperative for the governance is to ensure that there is fidelity to the vision, goals and objectives of the HSE Program, projects are successful in achieving their results within budget and schedule and that Program delivery and the resulting products are of the highest quality. To do this, the State has implemented a coordinated approach to QA/IV&V which includes QA/IV&V at both the Program-level and at the individual project-level. All QA/IV&V vendors are expected to work collaboratively within the Program to ensure project and Program success.

In this multi-project, multi-vendor environment, each project and each QA/IV&V vendor are required to:

- Maintain a clear focus on the enterprise approach and the establishment of an integrated platform of common Service Oriented Architecture (SOA) services and technology components essential to support the full enterprise of the health and human services programs and leverage and build upon the platform

- Maximize the containment of risks for a Program of this size and complexity and minimize issues related to duplication of efforts, systems integration and interface, future rework and others
- Ensure the effective and efficient allocation of State and Vendor resources and the sequencing of the planning, requirements and procurement efforts for all Project work streams
- Align with and support the State's effort to leverage the enhanced Federal Financial Participation (FFP) to the greatest extent possible and to reduce cost allocation requirements
- Comply with and support the governance of the Program in the context of each individual project

Additional details on the separation and coordination of roles and responsibilities within the projects and Program are provided in this RFP.

3.1.3 The HSE Platform

The HSE Platform is the foundation for building out all new functionality for programs and services to support a person/family centered model of practice. While the QA/IV&V scope described within this RFP does not focus on oversight of the HSE Platform, Vendors must have an understanding of the HSE Platform as this is a key architectural component for all projects within the HSE Program as shown in Figure 4. The HSE Platform's infrastructure is comprised of shared components and services that offer the capabilities defined in Table 55.

Table 5. HSE Platform Services and Capabilities

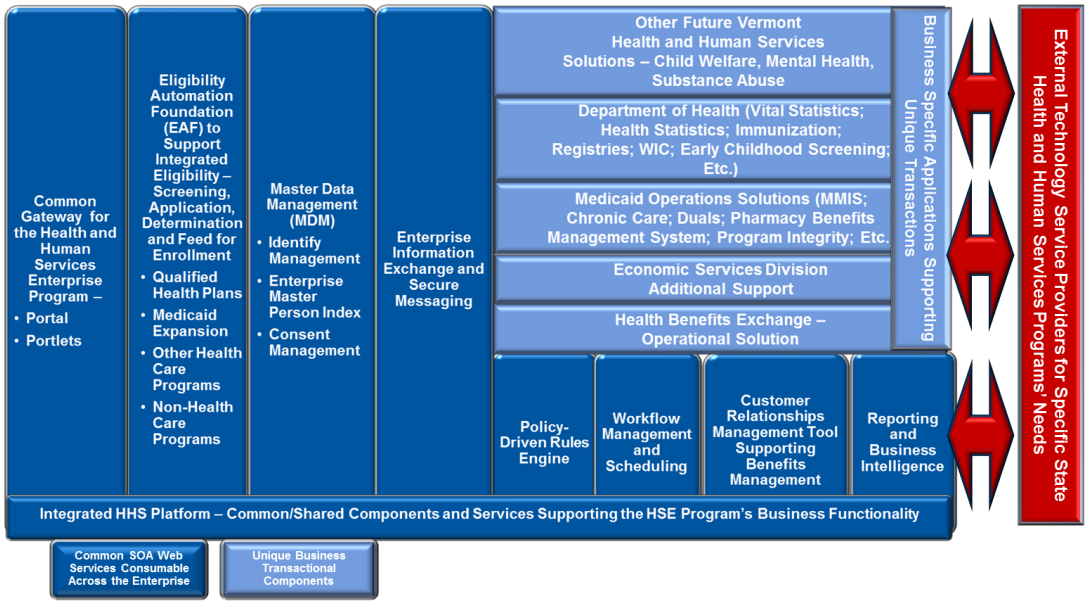
Identity Management	Ensure individuals are identified across the range of roles, health and human services programs that they interact with, and have access only to information and functionality for which they are authorized
Consent Management	Ensure that appropriate information is shared with only individuals that are authorized and have a need to access to it

Portal	Provide a consistent user interface and access to information and functionality
Enterprise Information Exchange (EIE)	Referred to as a gateway, or service bus, which provides a standards based mechanism for integrating with and sharing information among the full range of health and human services and administrative applications
Master Data Management (MDM)	Includes Master Person Index, and Master Provider Index to ensure a common view and single version of the "truth" across AHS programs
Rules Engine	Define and manage the business rules that will drive eligibility assessments for AHS programs
Eligibility Automation Foundation	Provide shared functionality for eligibility screening, application and determinations services for AHS programs
Content Management	Allow management of and access to a wide range of information and media
Analytics and Business Intelligence (BI) Tools and Repositories	Create reports and dashboards to shed light on and manage current operations, and to develop analytical and predictive analyses for future planning and policy development
Collaboration Capabilities	These capabilities include: Service Coordination (Secure Messaging and Shared Case Notes), Client and Provider Look-Up and Query, Referral Management (Create Referral and Manage Referral), and Alerts and Notifications
Service-Oriented Architecture (SOA)	Architected services that are composed of discrete software agents that are loosely coupled to other enterprise components. These services are re-usable for the construction of additional applications
Universal Customer Management (UCM)	Ensure individual (member) data is managed holistically. This is generally serviced by Customer Relationship Management (CRM) applications that touch multiple areas of a customer (member) activity. Services to be used include CRM 2.0 capabilities thus offering bi-directional communications and exchanges. This is the backbone of any customer management system

Enterprise Content Management (ECM) and Customer Communication Management	Allow for the management of structured and un-structured data across the enterprise. The customer communication management part refers to notifications constructed by the business to formally communicate with members by way of the enterprise
Business Process Management (BPM)	A SOA supported system that generates, stores, and re-uses business processes required to perform the necessary business requirements of the target solution

Figure 6 provides a conceptual view of these capabilities within the HSE Platform. The use of key HSE Platform technology components and their reusable and interoperability across AHS programs and services will be critical to achieving the AHS vision for the transformation of the State's health and human services.

Figure 6. Conceptual View of the AHS Health and Human Services Enterprise Platform



The HSE Program and Medicaid project teams, with the Department of Information and Innovation (DII), have developed guiding principles for the enterprise architecture and reuse of HSE Platform components to meet the needs of the Medicaid Projects. These are embodied in documents that can be found in the Procurement Library of the RFP. Through the QA/IV&V efforts, the Vendor must review and evaluate the extent to which the solution(s) leverage the HSE Platform in accordance with the guiding principles.

3.1.4 Role of Quality Assurance (QA) and Independent Verification and Validation (IV&V) Vendor within the Context of the HSE Program

The State has implemented a standardized set of requirements and expectations to support an effective and efficient coordinated approach to QA/IV&V across the HSE Program to ensure that constituent projects meet Program objectives and use consistent methodologies and tools to provide a cohesive view of the progress of the projects under the oversight and direction of the HSE Program. Several systems development and implementation projects under the HSE Program will implement QA/IV&V services aligned with State, Federal and industry best practices. This holistic approach to quality provides both project and Program-level capabilities to fulfill the AHS vision for the HSE Program and to ensure success.

All methodologies, practices, tools and artifacts for the QA/IV&V of the systems development and implementation project should abide by the standards set forth by the State and the HSE Program and align with Federal guidance, as well as industry standards. These include, but are not limited to:

- State of Vermont Enterprise Project Management Office (EPMO) standards (see http://epmo.vermont.gov for more information)
- Federal requirements and guidance, including at least those found in 45 Code of Federal Regulations (CFR) Part 95.626
- The Project Management Institute (PMI) as referenced by the Project Management Body of Knowledge (PMBOK) and other documentation (see http://www.pmi.org for more information)
- Institute of Electrical and Electronics Engineers (IEEE) standards, including, but not limited to IEEE Standards1012 System and Software Verification and Validation, 12207 Software Life Cycle Process; 730 Software QA Processes; 1074 Developing a Software Project Lifecycle Process; 828 Configuration Management Plans; and, 29148 Systems and Software Engineering -- Life Cycle Processes --Requirements Engineering, etc. (see http://www.ieee.org for more information)

The Vendor shall use QA/IV&V processes iteratively throughout the System Development Lifecycle (SDLC) (including transition to operations and CMS certification processes, as needed) to determine whether the plans, methods and products delivered fulfill the requirements placed on them by previous iterations, phases and steps and are internally complete, consistent, and sufficiently correct to adequately support the next iteration, phase and step.

The Vendor shall use QA/IV&V processes to examine and validate the complete application (software, hardware, procedures, and documentation) to determine whether requirements have been met. The Vendor will identify deficiencies or gaps in processes, within systems and

between systems and will provide corrective recommendations. The Vendor will work with the State and the DII Vendor to remediate the issues identified in the corrective recommendations.

QA/IV&V shall begin at the start of the SDLC to ensure that the process will move in a direction to eventually satisfy requirements.

QA/IV&V shall occur periodically throughout the SDLC and upon completion of deliverables to ensure the deliverable meets the latest requirements (regardless of changes to these requirements during the project).

In addition to the scope discussed in this RFP, Vendors should review the contents of the following RFPs to understand the scope of work being asked as part of this QA/IV&V effort:

- **Medicaid Management Information System Design, Development, and Implementation, Medicaid Operations Services, and Integrated Contact Center System**
  http://dvha.vermont.gov/administration/7mmis-information-technology-rfp.pdf
- **Care Management**
  http://dvha.vermont.gov/administration/2vermont-care-management-rfp.pdf
- **Pharmacy Benefit Management**
  http://dvha.vermont.gov/administration/1vermont-pbm-rfp-final.pdf

The Vendor will validate data usage and consistency across the Enterprise (Medicaid). The Vendor will assist the State with Medicaid program integration across the Enterprise. The Vendor will work with the State and DDI Vendors on systems integration and workflow across programs. The Vendor will review and become familiar with other procurement and system documentation included in the Procurement Library such as the enterprise architecture principles for the HSE Platform. Additional detailed documentation will be provided to the Vendor upon initiation of the project.

3.1.5 Medicaid Implementation Projects In Scope

There are three DDI Procurements and four implementation efforts within the scope of the requested QA/IV&V services for the MMIS Core RFP (refer to definition of Medicaid Projects on page 35).

3.1.5.1 MMIS, Medicaid Operations Services and Contact Center System and Services

The MMIS, Medicaid Operations Services and Contact Center system and services will replace the current technologies (except for those of the evolving HSE Platform) and services in place to support the Vermont Medicaid enterprise and AHS as a whole. This Project adds further capabilities and flexibility to allow for ongoing enhancements to the way that Vermont provides health and human services to its residents.

- The technology System and Services will achieve the following:
  - Provide functional support for the Vermont Medicaid enterprise, with the capability to expand to additional services as described in this document
  - Comply with CMS' Seven Conditions and Standards and Medicaid Information Technology Architecture (MITA) 3.0
  - Leverage, to every extent possible, the State of Vermont HSE Platform technologies and standards
  - Attain MMIS CMS certification
  - Support annual State Self-Assessment reviews
  - Interface with Federal and State partner systems to ensure that all necessary data flows from the MMIS to the relevant systems, and that relevant data required for service validation, payment, and other reporting and analysis flows from Federal and State systems to the MMIS
  - Operate and maintain the technology implemented
- The Services that will be provided by the MMIS Vendor will include the following:
  - Interface with the State eligibility operations to ensure that eligible Members are appropriately enrolled
  - Develop, manage, and provide support to the Provider network
  - Process all claims and prepare claims for payment, in coordination with other systems
  - Issue relevant and valid payments
  - Maintain financial data for all programs managed through the MMIS as the auditable Fiscal Agent entity for Medicaid
  - Conduct and produce necessary and required data analytics and reporting

The State has separated the MMIS Services into five (5) work streams aligned to the MITA 3.0 Framework as described in the Table 66.

Table 6. MMIS Solution Work Streams Alignment to MITA Business Processes

WORK STREAM NAME	ALIGNMENT WITH MITA 3.0
Operations Management	Operations Management includes the core operations and associated activities related to accepting, processing, adjudicating and managing claims. The work stream includes the State's Coordination of Benefits (COB) activities and activities around Third Party Liability (TPL), including but not limited to, estate recovery, casualty recovery, cost-avoidance, annuities and trusts.
Financial Management	Financial Management handles all accounts receivables, accounts payables and budgeting.
Member Services	Member Services is responsible for a member's PCP enrollment, member information, and member communications. A notable exception to this work stream in Vermont is the absence of eligibility determination, which is managed by the State's Department for Children & Families Economic Services Division using the IE (ACCESS) system or its replacement. The work stream includes the management of Member Fair Hearings, Grievances and Appeals for eligibility determination and covered services Contact Center Member Services is responsible for Tier 1 member-facing enrollment, disenrollment, member information request, and member communication support. This includes outreach, education and outgoing mailing support.
Provider Management	Provider Management is responsible for all provider eligibility, enrollment, disenrollment, and management functions. The work stream includes the management of Provider

WORK STREAM NAME	ALIGNMENT WITH MITA 3.0
	Grievances and Appeals. Contact Center Provider Management is responsible for all provider eligibility, enrollment, disenrollment, and the management of the services functions using the MMIS and a Contact Center-provided CRM solution.
Data Analytics	Data Analytics is responsible for the overall management of data contained within the MMIS and interfaces with partner systems to provide robust data analytics needed for management of programs. This work stream includes the Program Integrity functions.

3.1.5.2 Care Management

Department of Vermont Health Access (DVHA), as part of AHS, assists Members in accessing clinically appropriate health services, administers Vermont's public health insurance system efficiently and effectively, and collaborates with other health care system entities in bringing evidence-based practices to Vermont Medicaid Members.

Vermont is implementing a robust, contemporary Care Management Solution for early identification of member healthcare needs, coordination of care and results reporting. The solution will be built on MITA 3.0 compliant architecture meeting CMS' Seven Conditions and Standards.

The Vermont Care Management Solution will support the Agency and Departments' vision of an 'Agency of One' – aiming to change the paradigm from a program-centered service delivery system to a person-centered service delivery system by:

- Collecting, organizing and analyzing information in a safe and secure manner; optimizing workflows; and facilitating and strengthening the State's decision-making ability on health services
- Increasing access to integrated information so that staff can work with Members to identify appropriate services and connect them with those resources

- Enabling case managers, providers, and other involved partners to coordinate care and collaborate with each other, and with the member for improved health, safety and self-sufficiency
- Evaluating the cost-effectiveness of health services rendered across programs and the Agency

The Solution will support Vermont AHS' care management needs in the following areas:

- Utilize clinically relevant predictive risk modeling tools and gaps in care analysis of various Member populations for early screening, case identification and risk stratification of Medicaid Members including but not limited to –
    - Members who will benefit most from some form of care management intervention(s) (those with high utilization patterns, multiple providers, multiple conditions, polypharmacy, care gaps; and those who are at risk for chronic disease sequela)
    - Members who are not currently at risk but may become at risk in the future
- Proactive outreach to Members who are at risk, and to their providers to offer information, guidance and support to –
    - Improve health outcomes by: closing gaps in care, increasing adherence to evidence-based care, increasing the use of preventive care, and improving self-management and provider management of chronic illnesses
    - Lower healthcare costs by minimizing redundancies and reducing utilization and expenses
- Develop, monitor, share and reassess an evidence-based care plan to ensure clinically appropriate health care information and services are provided and communicated to improve the health outcomes of Medicaid Members.
- Coordinate efficient and effective delivery of health care with Medicaid Members, their providers and community partners by removing communication barriers, bridging gaps, and exchanging relevant and timely Member information.
- Conduct real-time care management analytics that include the ability to collect multiple sources of data (including hospital census, claims data, pharmacy data, and clinical/bio-medical data from providers) to identify opportunities that a Member or provider can take to improve financial and clinical outcomes.
- Provide robust and user-friendly reporting capabilities and web-based tools necessary to effectively conduct Vermont Care Management Programs' strategic planning, quality,

and performance management including clinical, utilization and financial changes among intervened populations.

3.1.5.3 Pharmacy Benefits Management

As part of this mission, the DVHA administers the pharmacy programs for the State of Vermont with support from its Pharmacy Benefit Manager (PBM) partner.

Vermont has procured a contemporary Pharmacy Benefit Management solution that is built on MITA 3.0 compliant architecture meeting CMS Seven Conditions and Standards. The PBM solution will support AHS and DVHA goals, namely to ensure the availability of clinically appropriate medication services at the most reasonable cost possible, and to provide access to high quality pharmacy benefits in Vermont's publicly-funded programs.

In support of the AHS and DVHA mission, the goal of DVHA's pharmacy programs is to assure access to and availability of safe, efficacious, and clinically appropriate drug therapy at the lowest cost possible. DVHA has chosen a PBM partner that values business processes that reduce administrative burden on DVHA, providers, and members throughout the duration of the contract. DVHA's PBM partner will support Vermont's health reform initiatives, including the Governor's GMC 2017/Vermont's Publicly-funded health care model, single formulary vision, and payment reform models. GMC 2017 is Green Mountain Care 2017, Vermont's Universal, and Publicly-Financed Health Coverage Model (hereafter referred to as 'GMC 2017. For additional information see the MMIS Core RFP. The objectives are to support DVHA's pharmacy programs in the following areas:

Claims Processing and Operational Support

- Point-of-Sale (POS) claims processing system
- Automated Coordination of Benefits (COB)
- Post Payment Claims Management
- Provider Network Support, Call Center, and Portal
- E-Prescribing and E-Prior Authorization Capabilities

Pharmacy Benefit Management and Clinical Programs

- Utilization Management Programs
- Prior Authorization Program
- Drug Utilization Review

- State Maximum Allowable Cost (SMAC) Program and the Federal Upper Limit (FUL)
- Specialty Pharmacy
- Medication Therapy Management
- Benefit Design and Consultative Support
- Management of Physician-Administered Drugs
- Reporting and Analytics
- Quality Assurance
- Medication Therapy Management

Financial Management

- Management of State and CMS Drug Rebate Programs
- Support of Multistate Supplemental Rebate Consortium
- 340B Program Management

Additional Services: GMC 2017 Considerations

3.1.6 Project Objectives and Goals

The State has identified several business drivers for the procurement of QA/IV&V services to support the Medicaid Projects. These drivers include:

- **Implement QA/IV&V within a coordinated QA/IV&V approach established to assure the HSE Program objectives are achieved.** Ensure QA/IV&V activities for the Medicaid projects procurements complement the HSE Program approach which assesses quality at both the Program level and within the respective Projects to assure program objectives are achieved. Coordinate with other entities providing QA/IV&V to limit duplication of effort and share critical information.
- **Maintain/Secure funding from the CMS through adherence to Federal regulations.** Demonstrate compliance with CMS requirements by proactively assessing the Medicaid Projects and its deliverables against the criteria specified within the Medicaid Enterprise Certification Toolkit (MECT) checklists, the Seven Conditions and Standards and MITA 3.0 framework during execution of the DDI effort as opposed to upon completion. This assures early identification of non-compliance allowing the State to take corrective actions as needed to maintain/secure federal

funding. CMS provides funding to support the development and operation of the State's MMIS at 75-percent to 90-percent when specific criteria are met.

- **Provide independent, objective guidance and expertise to assure Medicaid Projects success and decrease implementation risks.** Gain perspective and recommendations on the health of the Medicaid Projects and associated deliverables from an experienced, neutral third party to assure the development of the solution is managed in accordance with practices that reduce risk and support achievement of the stated project objectives. Leverage assessments and deliverable reviews to ensure end users' practice needs drive the system NOT technology.

- **Provide oversight of systems integration across the Medicaid Projects.** Identify potential risks, issues and/or dependencies with system integration across the Medicaid Projects to ensure the end-to-end solution functions as planned.

- **Benefit from lessons learned from other implementation and redesign experiences to limit re-work.** Apply lessons learned from other IT projects generally, HSE Program and Medicaid Projects to identify potential issues and risks as early in the project life cycle as possible. Provide recommendations on a revised course of action to limit the impact of the potential issues and risks.

- **Reuse of common components within the HSE.** Ensure the Medicaid Projects to the extent possible and where appropriate, are leveraging investments the State has made, either through reuse of technologies already owned or through the use of Web services available in the Oracle-based SOA-compliant HSE Platform. This will prevent duplication of work and duplication of functionality within the AHS IT portfolio.

3.1.7 Project Approach

The State intends to award one (1) contract to a prime Vendor and any subcontractors to the prime Vendor to deliver the QA/IV&V services described in the scope of work. The Vendor will be responsible for providing QA/IV&V services for each of the three Medicaid Projects within this scope of work as well as interactions between those projects, DDI Vendors and resulting solutions.

The State is undertaking several large DDI initiatives at this time, some of which require QA/IV&V services. The Vendor will need to coordinate with other State, DDI Vendor and QA/IV&V vendor teams that are all operating within the discussed contexts. It is a mutual responsibility among all of these entities to ensure successful outcomes for individual projects and the HSE Program.

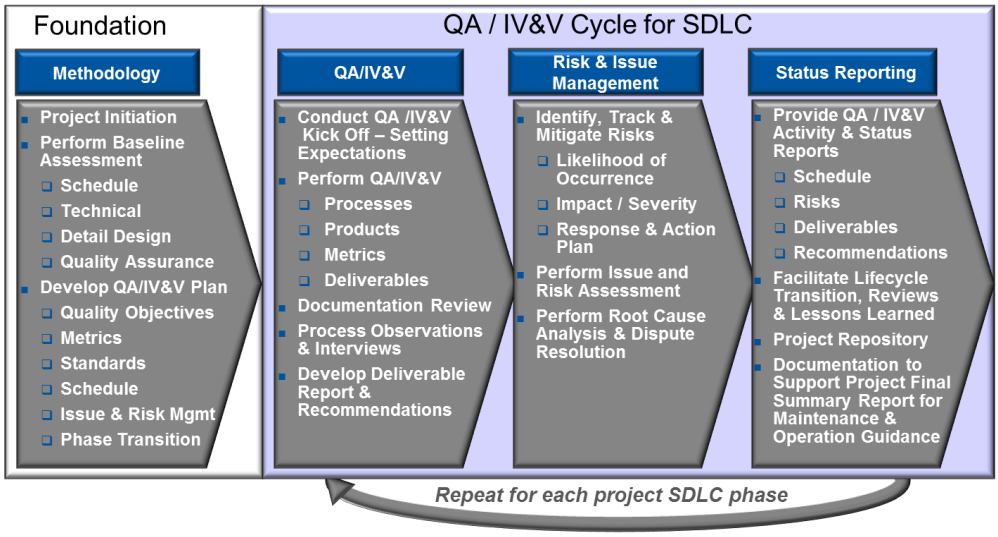
The QA/IV&V Services described in this RFP must comply with IV&V regulatory requirements detailed in 45 CFR 95.626 which require that IV&V efforts be conducted by an entity that is independent (e.g., technically, managerially and financially) from the State and DDI Vendor(s) to perform the following activities:

- Develops a project work plan
- Reviews and makes recommendations on the State's and Vendor's management of the project
- Reviews and makes recommendations on the technical and security aspects of the project
- Consults with stakeholders and assesses the user involvement and buy-in regarding system functionality and the system's ability to support program business needs
- Conducts an analysis of project performance sufficient to identify and make recommendations for improvement
- Provides risk management assessment and capacity planning services
- Develops performance metrics which allow tracking project completion against milestones set by the State

3.1.8 Envisioned Project QA/IV&V Strategy

The State envisions the QA/IV&V strategy will employ an iterative approach conducted as a partnership between the State and Vendor. An example is provided in Figure 7.

Figure 7. Example of Iterative QA/IV&V Strategy



The foundational phase establishes a performance baseline by conducting an initial QA/IV&V assessment for each of the systems identified in Medicaid Projects. This baseline assessment provides the State with actionable feedback and helps the Vendor quickly assess the current health of the project to identify strengths and opportunities for improvement. This phase includes development of a project QA/IV&V Plan that includes all Medicaid Projects and defines the approach the Vendor will leverage across project QA/IV&V activities to ensure the desired level of quality.

The cyclical phase contains several interconnected activities – periodic QA/IV&V assessments, deliverable reviews, ongoing risk and issue management and status reporting.

- As the Medicaid Projects progress through the lifecycle, the domains covered by the periodic QA/IV&V assessments will change. While some domains in the QA/IV&V assessments remain constant such as governance and communications, others will change based upon where the project is in the project life cycle such as test planning. As much as possible, these assessments are aligned to stage gates to support Go/No Go decisions. Due to the duration of some phases, assessments may be conducted in between stage gates.

- Deliverable reviews provide independent, detailed evaluations of project deliverables with a recommendation to the State on whether to accept or reject the deliverable.

- Ongoing risk and issue management provides an early warning system to the State of potential issues or risks not yet identified and/or recommendations on changes to the likelihood of occurrence and/or the impact of existing issues or risks. These timely recommendations ensure the appropriate level of visibility for high priority items between the periodic QA/IV&V assessments and deliverable reviews.

- Status reporting provides a snapshot of the QA/IV&V effort and any areas of concern.

This approach provides a balance of near-real time feedback on the Medicaid Projects health and detailed assessments based on past project performance in order to reduce risk and support the achievement of the Medicaid Project's objectives.

3.2 Major Tasks and Deliverables

During the course of the contract, the Vendor must provide, at minimum, the services and corresponding deliverables listed in Table 77 to include the project management and administrative responsibilities required for delivery. The Vendor must be capable of expanding the original concepts set forth in this RFP, under the direction of the State, to accommodate unforeseen developments that may take place during the term of this contract.

The Vendor shall provide deliverables to the designated point of contact from the State and, as required, Federal agencies in the agreed upon format. The State must provide written acceptance of all deliverables before they can be considered complete. For Vendor-led meetings, the Vendor shall provide minutes in an agreed upon format with the agreed upon elements.

Table 7. Summary of Tasks and Deliverables

TASK/DELIVERALBE(S)	DUE DATE
1. Develop, Maintain, and Execute the QA/IV&V Plan	
■ High-Level QA/IV&V Plan	Included in Response
■ Comprehensive QA/IV&V Plan	Within 10 Days of Award
■ QA/IV&V Plan Updates	Per Schedule
■ Work Plan	Within 15 Days of Award
■ Work Plan Updates	Per Schedule
2. Perform Initial, Periodic and Final QA/IV&V Assessments	
■ Initial QA/IV&V Report	Within 45 Days of Award or As Agreed
■ Periodic QA/IV&V Reports	Periodic
■ Final QA/IV&V Report	Upon Conclusion of QA/IV&V Activities
■ Meeting Minutes	After Each Meeting
3. Perform Ongoing Risk and Issues Management	
■ Risk and Issues Log (and/or Inputs to the Project Risk and Issues Log)	Ongoing
■ Recommended Risk/Issue Responses (e.g., for risks accept, transfer, mitigate, avoid) and Action Plans	Ongoing

TASK/DELIVERALBE(S)	DUE DATE
4. Review and evaluate DDI Vendor Deliverables	
■ Deliverable Review Procedures (Within Comprehensive QA/IV&V Plan)	Within 10 Days of Award
■ Review of Deliverable Expectation Documents	Per Schedule
■ Recommendation to Accept/Reject Deliverables with Supporting Comments	Per Schedule
■ Report on Status of Actions to Address Deliverable Deficiencies	As Needed
■ Meeting Minutes	After Each Meeting
5. Support MMIS Certification	
■ Evaluation of DDI Outcomes Against CMS Certification Expectations	Per Schedule
■ CMS Visit Support (before, during and after) including: ○ Preparation support for all certification activities as requested ○ Attendance on calls and at meetings, as needed ○ Analysis and proposed responses for issues that arise	Per Schedule
■ CMS Certification Report Review and Response	Per Schedule
6. Report on Status	
■ Status Reports	Bi-Weekly
■ Executive Status Reports	Periodically
■ Ad Hoc Reports	As Needed

TASK/DELIVERALBE(S)	DUE DATE
■ Meeting Minutes	Bi-Weekly and As Needed

3.2.1 Develop, Maintain and Execute the QA/IV&V Plan

The Vendor must draft a QA/IV&V Plan to describe their approach for assuring quality of the Medicaid Projects integrated and coordinated with the HSE that meets at minimum the tasks and deliverables defined within this RFP and the requirements identified in Template G. The requirements in Template G are the minimum set of areas the Vendor shall validate, evaluate and create a plan to remediate, if needed provide a recommended remediation plan to address any deficiencies in order to perform the tasks within this RFP. The Vendor shall make additional recommendations within the QA/IV&V Plan on the approach for assuring quality based on their experience, high risk areas and other considerations. **A high-level QA/IV&V Plan must be included in the response to this RFP.** The high-level QA/IV&V Plan must describe the proposed methodologies for managing quality across the key domains required to execute the full program life cycle from planning to transition to operations and identify metrics for tracking project performance against milestones. These areas may include, but are not limited to:

- Project Governance and Management
- Requirements Analysis and Management
- Use Case Development and Application (e.g., Supporting Design, Development, Testing, User Acceptance Testing-UAT and User Training)
- System Design (e.g., Conceptual and Detailed Designs)
- Development Methodology and Tools
- Testing Plan, Methodology and Reports (e.g., System, Integration and User Acceptance Testing)
- Defects Prevention, Detection and Fixes
- Integration and Interface Control Plan, Activities and Reports
- Configuration Management
- Data Standards, Conversion Planning and Execution
- Security and Privacy

- Deployment Planning and Alternatives
- User Training Plan and Implementation
- Knowledge Transfer and Transition Planning
- Hosting Environments
- Warranty Requirements and Compliance

The Vendor must also describe whether, and in what way, it applies widely adopted standards in its evaluation of Medicaid-related projects and transition to operations. Examples of such standards include, but are not limited to: Institute of Electrical and Electronics Engineers (IEEE) and Project Management Body of Knowledge (PMBOK).

After award, the Vendor must develop a comprehensive QA/IV&V Plan, based on the high-level plan, to include a work plan. The work plan must detail the tasks, durations, resources and sequencing to execute the QA/IV&V Plan. The work plan must support the State's schedule for delivery of all of the Medicaid Projects.

Key Activities

- Draft a high-level QA/IV&V Plan
- Expand the high-level QA/IV&V Plan to comprehensively address designated areas
- Review the QA/IV&V Plan with State of VT stakeholders
- Draft a Work Plan aligned to the QA/IV&V Plan and the State's Work Plan for DDI of the Medicaid Projects
- Execute the QA/IV&V Plan and Work Plan
- Periodically update the QA/IV&V Plan and Work Plan
- Present the QA/IV&V Plan and Work Plan to stakeholders from the State as needed

Deliverables

- High-Level QA/IV&V Plan
- Comprehensive QA/IV&V Plan
- QA/IV&V Plan Updates
- Work Plan

- Work Plan Updates

3.2.2 Perform Initial, Periodic and Final QA/IV&V Assessments

The Vendor must provide initial, periodic and final assessments of the Medicaid Projects. The purpose of these assessments is to provide an independent, objective review of performance to identify strengths, risks and other potential challenges as early in the project life cycle as possible. The assessment must identify which risks and potential challenges are the highest priority and provide recommendations to address, at a minimum, the areas with the highest risk. The scope of the assessment shall vary based upon the phase in the life cycle. The periodic assessments shall align with the project(s) stage gates. Additional assessments may be performed between stage gates as needed or recommended by the Vendor (and agreed to by the State). In addition to the areas identified in the QA/IV&V Plan and relevant requirements in Response Template G, the assessments must address the following areas per 45 CFR 95.626:

- Project management of both the State and vendor
- Technical aspects of the project
- User involvement
- Buy-in that the system will support the program business needs
- Review of past project performance
- Risk management process-identification and remediation

These assessments must be provided to both the State and appropriate Federal agency simultaneously, for each of the Medicaid Projects:

Key Activities

- Provide the State with an overview of the proposed framework for evaluation of project performance
- Ensure the Work Plan accurately reflects the activities and completion dates for the QA/IV&V assessment
- Collect information on from various sources such as interviews, project documentation, participation in meetings and others
- Analyze information collected using the agreed upon frameworks and standards to assess performance

- Draft the QA/IV&V assessment to include recommendations on how to address the highest priority improvement opportunities
- Deliver the QA/IV&V assessment to the appropriate stakeholders from the State and Federal agencies concurrently
- Review the QA/IV&V assessment with the State, DDI Vendor and/or other stakeholders and prepare minutes from the meeting
- Update the assessment to correct mistakes of fact, if needed, and provide a final version of the QA/IV&V assessment to the stakeholders previously identified

Deliverables

- Initial QA/IV&V Report
- Periodic QA/IV&V Reports
- Final QA/IV&V Report
- Meeting Minutes

3.2.3 Perform Ongoing Risk and Issues Management

The Vendor must anticipate and identify project risks and issues. Through participation in targeted meetings and other activities required to provide the services identified within this RFP, the Vendor will have access to a wealth of information to support risk and issue management. Risk and issue management may involve identification of new risks and issues or recommendations on known risks or issues (e.g., raising or lowering the importance or proposing a course of action). The Vendor must perform initial analysis on the risks and issues to focus the State's attention on those risks or issues of greatest importance. The Vendor must differentiate between risks and issues within the project team's control and those outside the project team's control (e.g., risks or issues due to dependencies on the HSE Platform). The Vendor shall perform risk and issue management activities for each of the Medicaid Projects, in accordance with each project's risk management plan.

Key Activities

- Identify risks and issues on an ongoing basis
- Perform initial analysis on the risks and issues to determine importance, whether they are within the project team's span of control and other factors
- Propose a recommended course of action for those risks or issues of greatest importance

- Review the risks, issues and proposed course of action with the State project team in a timely manner

Deliverables

- Risk and Issues Log (and/or Inputs to the Project Risk and Issues Log)
- Recommended Risk/Issue Responses (e.g., for risks accept, transfer, mitigate, avoid) and Action Plans

3.2.4 Review and Evaluate DDI Vendor Deliverables

The Vendor must provide an independent, detailed review of all Medicaid Projects' deliverables to assess the deliverable quality, alignment to project objectives, fidelity to State and Federal requirements, adherence to the project plan and other criteria yet to be defined. Assessment of compliance to CMS certification criteria documented in the MECT checklists is a critical component of the deliverable review process. Reviewing deliverables against these criteria during the DDI effort as opposed to the end enables the State to effectively perform deliverable reviews. The Vendor must develop and implement review procedures that allow completion of a deliverable review within five business days of submission to the Vendor.

For each deliverable, the Vendor must first review and make recommendations on the deliverable expectations document provided by the DDI Vendor. In addition, the Vendor will validate the documents, policies and procedures utilized and created by the DDI Vendor. The Vendor will verify and validate the existence of the deliverables, document any deficiencies and propose a plan to help the State and the DDI Vendor remediate identified deficiencies. The Vendor will document their findings and the proposed remediation plan in format, using language that is useful to the State of Vermont. These documents will be provided in a timely fashion, as agreed upon by the State of Vermont. As appropriate, the Vendor shall recommend inclusion of requirements from Response Template G into the deliverable expectations documents. The requirements shall be used as a minimum set of requirements and the Vendor shall augment as needed based on its experience. The deliverable expectations document shall be the basis for the Vendor's formal recommendation to accept or reject a deliverable. The State must approve any changes to the deliverable expectations document and share it with the Vendor well in advance of the deliverable due date to establish expectations.

The Vendor may employ different techniques to gather the information needed to support a deliverable review such as review of intermediary drafts, participation in deliverable walkthroughs with the DDI Vendor and other meetings as necessary. As part of the review, consideration must be given to the potential opportunities and/or impacts from the HSE and other State projects underway. The criteria within the agreed upon deliverable expectation document must be applied to make a recommendation to the State on whether to accept or reject the deliverable.

The Vendor must document and make available to the DDI Vendor and State any findings in support of the recommendation to accept or reject a deliverable. The Vendor will create a proposed remediation plan to work in collaboration with the State of Vermont and the DDI Vendor to address deficiencies. The Vendor shall be required to monitor any action required to address deliverable deficiencies in a form that can be provided to the State.

The Vendor shall document minutes from meetings held to review the Vendor's recommendations on deliverable acceptance.

The project deliverables targeted for review and evaluation include, but are not limited to, those set forth in the table below. More information on the deliverables is located within the Medicaid-related RFPs.

Table 8. MMIS Solution Vendor Deliverables by Task

TASK	DELIVERABLE
Task 0 - Project Monitoring and Status Reporting	Deliverable 0 - Project Status Reporting (Recurring throughout the length of the Project, including DDI and M&O)
Task 1 – Project Initiation and Planning	Deliverable 1 – Project Kick-off Presentation
	Deliverable 2 – Project Management Plan including sub-component plans (i.e. Risk Mgmt Plan)
	Deliverable 3 – Project Work Plan and Fully Resourced Schedule
	Deliverable 4 – Staffing Plan
	Deliverable 5 – Requirements Analysis, System Design and Development Strategy
	Deliverable 6 – System Implementation Strategy
	Deliverable 7 – Master Testing Strategy

TASK	DELIVERABLE
	Deliverable 8 and so on below – Requirements Traceability Plan
Task 2 – Requirements Analysis and System Design	Deliverable 8 – Functional Specification and System Design Document
	Deliverable 8 – Data Integration and Interface Design Document
	Deliverable 10 – System Architecture
	Deliverable 11 – Technical Design Document
Task 3 – System Configuration and Development	Deliverable 12 – System Implementation Plan
	Deliverable 13 – Data Integration and Synchronization Plan
	Deliverable 14 – System Maintenance Support Plan
Task 4 –Testing	Deliverable 15 – Test Plan
	Deliverable 16 – Test Scenarios, Test Cases and Test Scripts
	Deliverable 17 – Documented System Test Results
Task 5 – Training	Deliverable 18 – Training Plan
	Deliverable 19 – Training Manuals, End-User Guides and Materials

TASK	DELIVERABLE
	Deliverable 20 – Documented Evidence of Successful End-User Training
	Deliverable 21 – Operations Quality Plan
Task 6 – Deployment	Deliverable 22 – Deployment Plan
	Deliverable 23 – CMS Certification Planning
	Deliverable 24 – System Incident and Defect Resolution Report
	Deliverable 25 – Completed Detailed Functional and Technical Specifications Traceability Matrix
	Deliverable 26 – System Source Code and Documentation
	Deliverable 27 – Performance SLAs
Task 7 – Phase Closeout	Deliverable 28 – Phase Closeout
Task 8 – System M&O	Deliverable 29 – System Incident Reports – M&O
	Deliverable 30 – Adaptive Maintenance Reports
	Deliverable 31 – System Enhancement Reports
	Deliverable 32 – Service Desk Support Plan
Routine	Deliverable 33 – Monitoring the implemented system(s)

TASK	DELIVERABLE
Operations	Deliverable 34 – Weekly reporting of any problem identified
	Deliverable 35 – Monthly Status Reports
CMS Certification	Deliverable 36 – CMS Certification Documentation
	Deliverable 37 – CMS Certification Electronic Document Storage

Table 9. Care Management Vendor Deliverables by Task

TASK	DELIVERABLE	PHASE 1	PHASE 2	M&O
Task 1 – Project Initiation and Planning	Deliverable 1 – Project Kick-off Presentation	X	X	
	Deliverable 2 – Project Management Plan	X		
	Deliverable 3 – Project Work Plan and fully resourced Schedule	X	X	
	Deliverable 4 – Requirements Analysis, System Design and Development Strategy	X		
	Deliverable 5 – System Implementation Strategy	X		
	Deliverable 6 – Master Testing Strategy	X		
	Deliverable 7 – Requirements Traceability Plan	X		

TASK	DELIVERABLE	PHASE 1	PHASE 2	M&O
Task 2 – Requirements Analysis and System Design	Deliverable 8 – Functional Specification and System Design Document	X	X	
	Deliverable 9 – Data Integration and Interface Design Document	X	X	
	Deliverable 10 –System Architecture	X	X	
	Deliverable 11 – Technical Design Document	X	X	
Task 3 – System Configuration and Development	Deliverable 12 – System Implementation Plan	X	X	
	Deliverable 13 – Data Integration and Synchronization Plan, including multiple test files (MMIS/claims, PBM, eligibility, VCCI legacy, etc.)	X	X	
	Deliverable 14 – System Maintenance Support Plan	X	X	
Task 4 – Testing	Deliverable 15 – Test Plan	X	X	
	Deliverable 16 – Test Scenarios, Test Cases and Test Scripts, using VCCI legacy and live data co-developed with VT staff	X	X	
	Deliverable 17 –Documented System Test Results	X	X	
Task 5 – Training	Deliverable 18 – Training Plan	X	X	
	Deliverable 19 – Training Manuals, End-User Guides and Materials	X	X	

TASK	DELIVERABLE	PHASE 1	PHASE 2	M&O
	Deliverable 20 – Documented Evidence of Successful End-User Learning	X	X	
Task 6 - Deployment	Deliverable 21 – Deployment Plan	X	X	
	Deliverable 22 – CMS Certification	X	X	
	Deliverable 23 – System Incident and Defect Resolution Report	X	X	
	Deliverable 24 – Completed Detailed Functional and Technical Specifications Traceability Matrix	X	X	
	Deliverable 25 – System Source Code and Documentation	X	X	
	Deliverable 26 – Performance SLAs	X	X	
Task 7 – Phase Closeout	Deliverable 27 – Phase Closeout	X	X	
Task 8 – System M&O	Deliverable 28 – System Incident Reports – M&O			X
	Deliverable 29 – Adaptive Maintenance Reports			X
	Deliverable 30 – System Enhancement Reports			X
	Deliverable 31 – Operations and system administration procedures manual			X
	Deliverable 32 – Tier 2 Service Desk Plan			X

Table 10. Pharmacy Benefit Management Vendor Deliverables by Task

TASK	DELIVRABLE
Task 1 — Project Initiation and Planning	Deliverable 1 — Project Kick-off Presentation
	Deliverable 2 — Project Management Plan
	Deliverable 3 — Project Work Plan and Schedule
	Deliverable 4 — Monthly Project Status Reports
Task 2 — Requirements Validation	Deliverable 5 — Requirements methodology and Template
	Deliverable 6 — Cross-Walk of RFP Functional against Legacy System Functionality
	Deliverable 7 — Detailed Functional and Non-Functional Requirements Traceability Matrices
Task 3 — System Design	Deliverable 8 — Configuration Design Document
	Deliverable 9 — Data Integration and Interface Design Document
Task 4 — Configuration and Development	Deliverable 10 — Client Review of Configuration
	Deliverable 11 — Unit Testing Scripts and Results
Task 5 — Testing	Deliverable 12 — Documented System Test Results
	Deliverable 13 — User Acceptance
Task 6 — Training	Deliverable 14 — Training Plan
	Deliverable 15 — Training Materials
	Deliverable 16 — Documented Evidence of Successful End-User Training
Task 7 — Deployment	Deliverable 17 — Deployment Plan
	Deliverable 18 — CMS Certification
	Deliverable 19 — System Documentation
	Deliverable 20 — Performance SLAs
	Deliverable 21 — Rollout

Key Activities

- Develop the deliverable review procedures
- Review and make recommendations on the Deliverable Expectation Document (DED) for each project deliverable
- Coordinate with the State to obtain approval on the DED
- Perform independent deliverable reviews against the DED within five business days of deliverable submission
- Submit a recommendation to accept or reject each deliverable, with supporting rationale, to the State and Vendor
- Upon request, review the recommendation and supporting rationale with the State, DDI Vendor and/or other stakeholders and prepare minutes from the meeting
- Monitor actions required to address deliverable deficiencies in a form that can be provided to the State

Deliverables

- Deliverable Review Procedures (within the Comprehensive QA/IV&V Plan)
- Review of DED (per deliverable)
- Recommendation to Accept/Reject Deliverables with Supporting Comments (per deliverable)
- Report on status of actions to address deliverable deficiencies
- Meeting Minutes

3.2.5 Support MMIS Certification

The Vendor must support the State's efforts to secure MMIS certification for all Medicaid Projects from CMS. While the DDI Vendor(s) and the State will lead the process for the certification by CMS and prepare much of the documentation required for certification, the Vendor is expected to provide support and oversight to assure compliance to the MMIS certification criteria.

Through the other QA/IV&V tasks described in this RFP, the Vendor will, on an ongoing basis, assess the State's compliance with CMS certification criteria. In this task, the Vendor will ensure the State's processes are in alignment with its policies and aligned with the requirements for CMS certification. The Vendor will provide input to raise and address concerns about the ability

of the system to enable the State to meet the MMIS certification. The Vendor must work with the State to meet CMS criteria where gaps are identified and provide the State with pre/during/post meeting support for CMS visits and meetings. Finally, the Vendor must review the CMS certification report and assist with preparation of a formal response by the State, if needed.

The Vendor will be responsible to support, as needed, aspects of the certification process as described in the MECT located at http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MMIS/MECT.html or as described in any updated CMS guidance provided prior to the formal certification process.

Key Activities

- Assist in the review, evaluation and validation of the Medicaid Projects to determine if they meet CMS MMIS certification criteria
- Coordinate with the State and other vendors to meet specific CMS criteria
- Provide assistance to the State team before, during and after the certification visit to ensure that CMS needs are met, including, but not limited to:
    - Review and completion of checklists in preparation for onsite visits
    - In person and remote support of all MMIS Certification processes including the pre-certification meeting, entrance conference, on-site visits, exit conference, debriefings, and other activities as needed
    - Identification, analysis and resolution of issues from calls and visits
- Review the CMS certification report and prepare a formal response on behalf of the State if needed
- Evaluate and track the State's adherence to the MITA 3.0 Framework, the VT MITA State Self-Assessment, and the Seven Conditions and Standards

Deliverables

- Evaluation of DDI Outcomes Against CMS Certification Expectations
- CMS Visit Support (before, during and after) including:
    - Preparation support for all certification activities as requested
    - Attendance on calls and at meetings, as needed
    - Analysis and proposed responses for issues that arise

- CMS Certification Report Review and Response

3.2.6 Report on Status

The Vendor must attend bi-weekly status meetings with the State to provide an update on the QA/IV&V activities and deliverables in accordance with the Work Plan, results from the ongoing risk and issue management task and outstanding actions from the Review and Evaluate Vendor Deliverables task. In advance of the meeting, the Vendor must prepare a written report covering the following information in the format designated by the State:

- Reporting time period
- Summary of the current status (e.g., schedule, scope, budget, risks, issues)
- Major activities and deliverables completed in the last reporting period
- Major upcoming activities and deliverables for the next reporting period
- Status of existing risks/issues and identification of new risks/issues
- Remediation plans in in respect to addressing resolving deficiencies
- Other relevant topics (e.g., scope changes, decisions made)

Additionally, the Vendor must provide additional reports upon request to support updates to the Executive Committee, Program Director or other stakeholders. The reports may focus on an executive-level status of the QA/IV&V initiative, summary of a specific QA/IV&V assessment/deliverable or other QA/IV&V related topic depending on the State's needs.

Key Activities

- Prepare and distribute bi-weekly status reports to the designated point of contact in advance of status meetings.
- Participate in bi-weekly status meetings with the State.
- Provide periodic executive status reports on QA/IV&V reviews and recommendations to stakeholders such as the Executive Committee and Medicaid project teams regarding project status and risk anticipation, prevention and mitigation.
- Develop and deliver ad hoc reports regarding the QA/IV&V efforts to stakeholders such as the Executive Committee and Medicaid project teams upon request.
- Prepare and distribute minutes from the meetings to discuss the status and other QA/IV&V reports.

Deliverables

- Bi-Weekly Status Reports
- Executive Status Reports
- Ad Hoc Reports
- Meeting Minutes

3.3 Required Project Policies, Guidelines and Methodologies

The Vendor must comply with and incorporate into QA/IV&V activities all existing applicable laws, regulations, policies, standards and guidelines affecting information technology projects, and those which may be created or changed periodically. It is the responsibility of the Vendor to ensure adherence and to remain abreast of new or revised laws, regulations, policies, standards and guidelines affecting Project execution and the System.

3.4 Proposed Project Organizational Approach

As described previously, there is a governance structure in place for the HSE that provides direction and oversight to ensure that decisions are made effectively and efficiently, and that the project and ongoing operations have the resources required for success. The State is committed to ensuring the appropriate degree of quality management and oversight is applied at each level and project within the HSE Program. The Vendor must operate within the Project governance structure, as well as within the HSE Program governance structure for a coordinated approach to quality management.

The Vendor will likely interact with all of the following governing bodies and organizations that are engaged in the HSE Program/Project governance.

- **Executive Steering Committee (ESC):** Responsible for overall direction and strategy of the Health and Human Services Enterprise. It consists of members from the Agency of Human Services (and its departments), Agency of Administration and the Department of Information and Innovation.
- **Operational Steering Committee (OSC):** Participates in the planning and oversight of the HSE Program and the individual projects within the HSE Program. It advises the Program Director on direction of the HSE Program, monitors and reviews project and program status, decides on operational Program decisions, and provides input to strategies and plans for the HSE Program.
- **HSE Program Management Office (PMO)**: Responsible for ensuring the successful implementation of the Program, as well as providing Program-level oversight for all of

the projects chartered as part of the HSE. The HSE PMO will review project artifacts in relation to applicability to and reuse by other solutions and will manage the project scope and AHS/HSE comprehensive IAPD budget. The HSE PMO is led by the Program Director, who has responsibility to coordinate all PMO activities on a day-to-day basis. Additional functions codified within the HSE PMO as "PMO Towers" include Strategy, Execution and Shared Services. The HSE PMO reports to the Secretary of the Agency of Human Services...

- **Department of Information and Innovation (DII) Enterprise Program Management Office (EPMO):** Provides project management oversight on all IT activities over $100K by Vermont statute. These IT activities are assigned an EPMO Oversight Project Manager (OPM). The bulk of the oversight provided by the EPMO is focused on ensuring the completion of standard project management minimum deliverables, and complying with statutory requirements relative to IT Activity procurement over $100K, and Bulletin 3.5. The OPM (in conjunction with the Business) performs an initial project risk evaluation to determine the appropriate level of oversight for a project.

- **DII Technical Oversight:** Responsible for the architecture and technical direction, oversight, monitoring and approval of the technical deliverables. The primary point of contact for any DDI project is the DII Enterprise Architect that works directly with the project team to ensure alignment with Federal, State, AHS and HSE laws, mandates and guidance.

- **Program Quality Assurance:** Responsible for quality assurance of the HSE Program through performance of periodic Program health checks, recurring analysis and reporting of HSE progress along its chartered course, and ongoing Program risk and issue management support. The Program Quality Assurance function is in part responsible for ensuring a Programmatic approach to QA/IV&V is implemented throughout all of the HSE projects.

Using a traditional Responsible-Accountable-Consult-Inform (RACI) model table 8 summarizes the ongoing and planned QA/IV&V activities and the organizations involved. Strategy, foundational architecture, individual projects, and the integration of all HSE elements are all evaluated to ensure the State's requirements are met. While not all organizations listed have direct oversight responsibilities, each is involved in the quality process.

Table 11. RACI Matrix of Organizations Involved in Quality Management

QUALITY OVERSIGHT RACI	QA/IV&V Vendor	Technical Oversight	DDI Vendor	HSE PMO	DII E-PMO	Project Team	Program QA	OSC	ESC
Phase 1 - Project Exploration									
Publication of enterprise platform standards	I	A	I	I	A	I	C	I	I
Risk identification and reporting on proposed project support of program goals		C		I		A	R	C	I
Business case development and validation		C		A		R	C	I	I
Stage Gate Review (Go/No-Go)		C		R	I	R	C	C	A
Phase 2 - Project Initiation									
Project solicitation support and review – risk identification and reporting	C	C		C		A	R	I	I
Develop and obtain acceptance from the project sponsor, and other appropriate stakeholders, of QA/IV&V Plan for the effort	R	C		A		C	C		
Initial project risk evaluation to determine DII oversight	C	C		C I	R A	C	C	I	I
Conduct preliminary assessment of project efforts	R	C	C	C	I	A	C	I	
Provide review and recommendations related to policy, project management processes, project organization, and resources	R A	C		C I		C	C	I	
Contract review prior to finalization. Verify that stated need is answered with the proposed contract (per the State's Independent Review process)	C	C		A	R	C	C	I	I

QUALITY OVERSIGHT RACI	QA/IV&V Vendor	Technical Oversight	DDI Vendor	HSE PMO	DII E-PMO	Project Team	Program QA	OSC	ESC
Stage Gate Review (Go/No-Go)	C I	C		R	I	R	C	C	A
Phase 3 - Project Definition and Planning									
Development of Deliverable Expectation Documents (DED)	R	C	A	C I		C			
Review of DED to ensure deliverables will meet requirements	R	C	I	C		A			
Validation of requirements definition process	R A	C	C	C		C	C		
Provide review and recommendations related to policy, project management processes, project organization, and resources	R A	C		C I		C	C		
Quarterly Program Health Check	C	C	C	C		C	R A	C	C
Project QA/IV&V Assessments	R A	C	C	C	C	C	C	C	C
Develop performance measures to track project completion	R A	C	C	C		C	C		
Review of system design adherence to enterprise architecture	R	A	C	I		C	C		
Stage Gate Review (Go/No-Go)	C I	C	I	R	I	R	C	C	A

QUALITY OVERSIGHT RACI	QA/IV&V Vendor	Technical Oversight	DDI Vendor	HSE PMO	DII E-PMO	Project Team	Program QA	OSC	ESC
Phase 4 - Project Execution & Monitoring									
Risk/Issue monitoring and management	**R**		**R**	**R I**		**A**	**R**	**I**	**I**
Provide review and recommendations related to policy, project management processes, project organization, and resources	**R A**	**C**		**C**		**C**	**C**		
Review of key deliverables and work products	**R**	**C**	**R**	**I**		**A**			
Review of system demos and walk-throughs – evaluation of system ability to address requirements	**R**	**R**	**C**	**I**			**C**		
Program Health Check	**C**	**C**	**C**	**C**		**C**	**R A**	**C**	**I**
Project QA/IV&V Assessments	**R A**	**C**	**C**	**C**	**C**	**C**	**C**	**C**	**C**
Monitor the effectiveness of DDI contractor quality management practices	**R A**	**C**	**C**			**C**	**C**		
System Integration Testing (SIT)	**R**	**R A**	**R**	**I**		**R**			
User Acceptance Testing	**R**	**R A**	**C**	**I**		**R**		**I**	
Regression Testing	**I**	**R A**	**R**			**C**			
Review test plans, validate test execution, and review test reports	**R A**	**C**	**C**	**I**		**C**		**I**	
Stage Gate Review (Go/No-Go)	**C I**	**C**	**I**	**R**	**I**	**R**	**C**	**C**	**A**

QUALITY OVERSIGHT RACI	QA/IV&V Vendor	Technical Oversight	DDI Vendor	HSE PMO	DII E-PMO	Project Team	Program QA	OSC	ESC
Phase 5 - Project Close									
Review of key deliverables and work products	**R**	**C**	**R**	**I**		**A**			
Evaluate operations and maintenance procedures and any ongoing changes	**R A**		**C**	**C I**		**C**	**C**		
Final QA/IV&V report summarizing all assessment reports and recommendations prior to concluding QA/IV&V activities	**R A**	**C**	**C**	**C**		**C**	**C**	**C**	
Lessons Learned exercise and report	**C**	**C**	**C**	**A R**	**C**	**C**	**C**	**C**	**I**

R – Responsible (Those who do the work to achieve the task or deliverable)

A – Accountable (The one ultimately accountable for the correct and thorough completion of the deliverable or task. There must be only one Accountable specified for each task or deliverable)

C – Consulted (Those whose opinions are sought; and with whom there is two-way communication)

I – Informed (Those who are kept up-to-date on progress)

DDI – Design, Development, and Implementation

EC – Executive Committee

E-PMO – Enterprise Project Management Office

IV&V – Independent Verification and Validation

OSC – Operational Steering Committee

The sections below outline the responsibilities for the entities within the governance structure as well as other key roles that are involved in the DDI and QA/IV&V activities for the HSE Program and this Project.

3.4.1 Project Staffing

3.4.1.1 State of Vermont Project and Program Roles and Responsibilities

The State will identify a single point of contact to lead the QA/IV&V effort. Through this individual, the State will coordinate overall project management responsibilities including the availability of State and Vendor resources as required to support tasks and retain acceptance and approval authority. Specifically, the State will:

- Define the goals and objectives of the QA/IV&V effort and Medicaid Projects
- Communicate the goals and objectives of the QA/IV&V effort to all stakeholders
- Provide access to required stakeholders from the State and vendors to participate in the execution of QA/IV&V tasks
- Provide required documentation from the State and other DDI Vendor(s) to support execution of QA/IV&V tasks
- Collaborate with the Vendor to set deliverable expectations
- Approve final QA/IV&V deliverables developed and revised by the Vendor
- Monitor the Vendor's performance according to contractual obligations, provide improvement requests, and approve invoices as detailed in the final Contract

For more information on key State roles in addition to the governing bodies and entities identified earlier refer to the RFPs for the Medicaid Management Information System Design, Development, and Implementation, Medicaid Operations Services, and Integrated Contact Center System RFP and Integrated Eligibility Project listed in the Procurement Library. Additional detail on the project staff will be provided to the Vendor upon engagement and throughout the engagement.

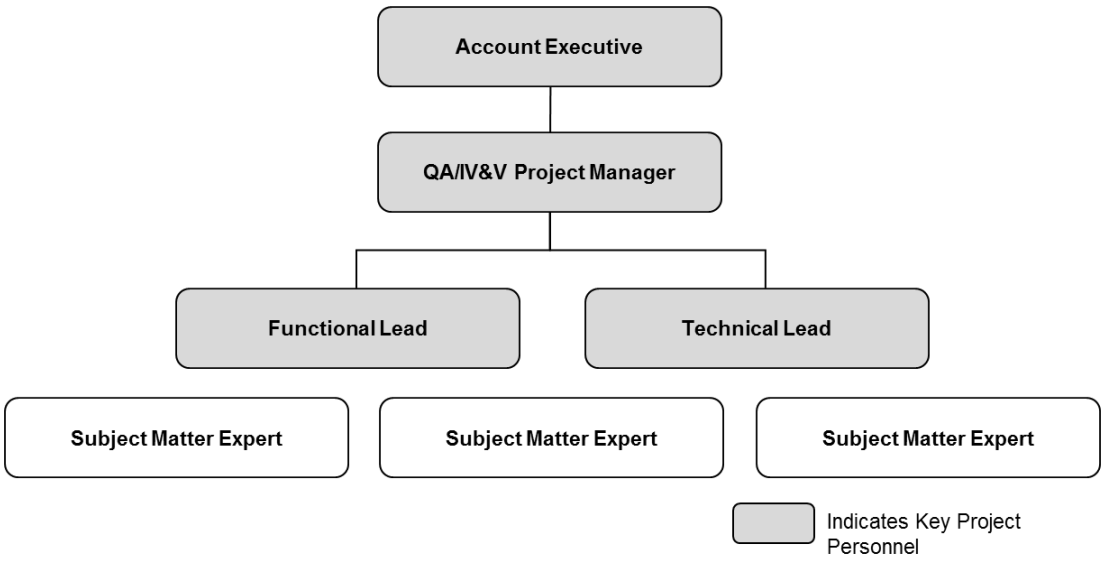
If the Vendor believes that certain work will be performed by the State's team or functional experts, and that work is not included in the Vendor's firm fixed price, the Vendor must identify the nature and associated hours of that work in an attachment to the Cost Proposal.

3.4.1.2 QA/IV&V Vendor Roles and Responsibilities

To successfully perform the QA/IV&V tasks defined within this RFP, the Vendor will need a team with deep expertise across QA/IV&V processes, Health and Human Services programs, IT program/project management and technical domains. The following diagram depicts a proposed staffing model to provide the leadership and supporting subject matter expertise required to support this QA/IV&V effort. The State is open to alternate staffing models. The Vendor should provide sufficient staffing to support the structure they expect to use for this engagement and its alignment with the goals, objectives and requirements in this RFP.

It is expected that Vendor will propose a staffing model that provides all expertise needs stated and implied, as well as any additional needs that the Vendor perceives based on past experience. The Vendor should demonstrate in their response to this RFP their ability to adjust staffing or expertise needs (add or replace staff) throughout the project should staffing or expertise needs change during the engagement period.

Figure 8. Proposed QA/IV&V Staffing Model



It is the Vendor's responsibility to warrant that the Vendor and its principals are eligible to participate in all work and transactions and have not been subjected to suspension, debarment, or similar ineligibility determined by any Federal, State or local governmental entity and that the Respondent is in compliance with the State of Vermont statutes and rules relating to procurement and not listed on the federal government's terrorism watch list as described in Executive Order 13224. Entities ineligible for federal procurement are listed at http://www.epls.gov.

3.4.1.2.1 Vendor Key Project Personnel (KPP) Roles

The term "Key Project Personnel," for purposes of this procurement, means Vendor personnel deemed by the State as both instrumental and essential to the Vendor's satisfactory performance of the requirements contained in this RFP. The Vendor may or may not have personnel other than the stated Key Project Personnel proposed as part of their response to this RFP.

The State expects the Key Project Personnel identified will be engaged to support the appropriate tasks and deliverables to leverage their expertise. The State will consider suggestions for alternative alignment of duties within the submitted Proposal. Changes to the proposed positions, staff and responsibilities will only be allowed with prior written permission from the State. If the Vendor believes that an alternative organizational design could improve service levels or decrease costs, discuss these options and their benefits within the response templates for this RFP.

Four Key Project Personnel must be proposed: an Account Executive, QA/IV&V Project Manager, a Functional Lead and a Technical Lead. These Key Project Personnel must be supported by a team of subject matter experts with experience in the requisite areas.

- All proposed key staff must have a minimum of five years working in public sector health and human services IT industry and in their proposed area of expertise doing work on similar projects as that described in the RRP
- The Account Executive must be available as needed to fulfill their responsibilities and meet the State's needs
- At a minimum, the QA/IV&V Project Manager must be full-time and dedicated solely to the Vermont Medicaid Projects' account unless the Vendor provides alternative solutions that meet State's approval. Vendors must propose a QA/IV&V Project Manager who will be available for the duration of the project. This individual will be the primary contact for the State on a day-to-day basis. The QA/IV&V Project Manager may work on-site and remotely as needed to fulfill his/her responsibilities – this proposed approach to on-site staffing should be described in the Vendor response All other Key Project Personnel and subject matter experts must be available according to the agreed upon Work Plan.

The Vendor shall define additional staffing levels required to accomplish the tasks defined in this RFP using Response Template E (Project Organization and Staffing). The State retains the right to approve or disapprove proposed staffing. The State reserves the right to require the Vendor to replace specified contractor employees. The Vendor agrees to substitute, with the Department's prior approval, any employee so replaced with an employee of equal or better qualifications. The Vendor agrees to propose within 30 days, and appropriately staff within 45 days, any

changes made to Key Project Personnel, regardless of the reason for the change. The Vendor shall provide the State a minimum of two business days' notice when they are terminating or changing Key Project Personnel.

The Vendor must include names and resumes for proposed Key Project Personnel as part of its Proposal. The Vendor must ensure Key Project Personnel have, and maintain, relevant current license(s) and/or certification(s).

The following table provides the required Key Project Personnel positions, corresponding roles and responsibilities and minimum qualifications for each. In addition to these roles, the Vendor should identify a combination of Key Project Personnel that are subject matter experts that meet the expertise needs stated below, as well as any areas of expertise the Vendor deems appropriate for this engagement. Other positions may be proposed at the Vendor's discretion.

Table 12. Key Project Personnel Roles, Responsibilities, and Qualifications

TITLE	ROLES AND RESPONSIBILITIES	EXPECTED QUALIFICATIONS

TITLE	ROLES AND RESPONSIBILITIES	EXPECTED QUALIFICATIONS
Account Executive	The Account Executive: • Serves as the primary point of contact with the Project Executive Sponsor, the HSE Executive Committee and other State executives as needed for activities related to contract management, dispute resolution, for the duration of the Contract • Is authorized to commit the resources of the Vendor in matters pertaining to the performance of the Contract • Is responsible for addressing any issues that cannot be resolved with the Vendor's Project Manager • Is responsible for all IV& V subcontractor relationships	• Minimum of five (5) years' direct project oversight and authority over large-scale government health and human services system implementation projects in excess of 10 million dollars and at least five (5) years' experience in QA/IV&V for a total of ten (10) years' experience overall • Special consideration will be given to those who have previously managed Medicaid project implementations and other related projects

TITLE	ROLES AND RESPONSIBILITIES	EXPECTED QUALIFICATIONS
QA/IV&V Project Manager	The QA/IV&V Project Manager: • Acts as the single point of contact for the State for all aspects of the QA/IV&V project • Is responsible for all scheduling and operational correspondence between the State and the Vendor • Develops, delivers and supports all reports sent to the State and Federal partners, including all status reporting • Ensures alignment of all project QA/IV&V standards with Program, State and Federal expectations • Provides the leadership, creating standards and processes required for the successful execution of the QA/IV&V project • Manages the QA/IV&V project (i.e., scope, schedule and budget and resources) and reports on these • Is accountable for execution of all tasks and deliverables specified within this RFP • Ensures all QA/IV&V deliverables meet state and/or federal defined quality standards • Delivers briefings to the State project team leadership with support from the Vendor team as needed • Is responsible for all IV & V subcontractor relationships	• Must have a minimum of five (5) years' direct project oversight and authority over large-scale government health and human services system implementation projects in excess of 10 million dollars and at least five (5) years' experience in QA/IV&V for a total of ten (10) years' experience overall • Must have a minimum of five (5) years' experience creating QA/IV&V processes and plans directly related to Medicaid implementation projects, of similar size and complexity to the Medicaid Projects described within this RFP, to include industry-standard and best practices regarding quality, quality assurance and quality control principles and techniques • Must have a Bachelor's degree or equivalent experience preferably in Information Technology, Engineering or a business or related field. • Should possess Project Management Professional (PMP) or equivalent certification • Must have excellent verbal and written communication skills • Must be able to communicate effectively with clients and technical staff in English • Special consideration will be given to those who have previously managed Medicaid project implementations and who have experience working with HIPAA privacy and security rules

TITLE	ROLES AND RESPONSIBILITIES	EXPECTED QUALIFICATIONS

Functional Lead	The Functional Lead:
	• Provides input on the QA/IV&V Plan and Work Plan to ensure appropriate review of project processes and artifacts
	• Is primarily responsible for development of functional aspects of QA/IV&V assessments
	  ○ Leads review of non-technical deliverables and provides recommendations to accept or reject with supporting rationale and recommendations for remediation
	  ○ Conducts reviews of requirements validation efforts, User Acceptance Testing, deployment planning and training and other business linked components of the DII vendor's SDLC efforts
	• Participates in review of technical deliverables
	• Proactively identifies project and Program risks and issues and proposes recommended courses of action as necessary
	• Engages and coordinates functional subject matter experts to execute QA/IV&V tasks as needed
	• Provides input on the status reports
	• Supports other tasks as identified by the QA/IV&V Project Manager
		• Must have a minimum of five (5) years direct experience with Medicaid health and human services business operations and related concepts including requirements development and validation, system configuration to meet business needs, and User Acceptance Testing (e.g., role of Business Analyst)
		• Must have a Bachelor's degree preferably in Information Technology, Engineering or a business or related field. Relevant experience with Medicaid project implementations may be considered in lieu of degree
		• Must demonstrate an understanding of Federal requirements for business, systems and Federal funding for all systems and programs in scope.
		• Must demonstrate experience using the MITA 3.0 framework, the Seven Conditions and Standards and all recent changes from the Accountable Care Act and other Federal and State laws, mandates and guidance
		• Must demonstrate experience with CMS MMIS Certification processes
		• Should have significant experience with industry-standards and best practices regarding quality, quality assurance and quality control principles and techniques

TITLE	ROLES AND RESPONSIBILITIES	EXPECTED QUALIFICATIONS

Technical Lead	The Technical Lead:
	• Provides input on the QA/IV&V Plan and Work Plan
	• Is primarily responsible for development of non-functional (e.g. technical, implementation, technical operations, usability, performance, etc.) aspects of QA/IV&V assessments
	  ○ Leads review of technical deliverables and provides recommendations to accept or reject with supporting rationale
	  ○ Conducts reviews of non-functional requirements validation efforts, Security assessments, SDLC Testing, Systems integration with HSE Platform, deployment planning and other technical linked components of the DII vendor's SDLC efforts
	• Participates in review of functional deliverables
	• Proactively identifies project and Program risks and issues and proposes recommended courses of action as necessary
	• Engages and coordinates subject matter experts to execute QA/IV&V tasks as needed
	• Provides input on the status reports
	• Supports other tasks as identified by the QA/IV&V Project Manager
		• Must have a minimum of five (5) years direct experience in the oversight of the technical aspects of large-scale government health and human services system implementation projects (e.g., role of architect, development lead)
		• Must have a Bachelor's degree preferably in Information Technology, Engineering or a business or related field. Relevant Medicaid project implementation experience may be considered in lieu of degree
		• Must have significant experience with the specified architectural/design concepts (e.g. service-oriented architecture) and technologies in use on this project and Program
		• Must demonstrate experience using the MITA 3.0 framework, the Seven Conditions and Standards and all recent changes from the Accountable Care Act and other Federal and State laws, mandates and guidance
		• Must demonstrate experience with CMS MMIS Certification processes
		• Should demonstrate significant experience with industry-standards and best practices regarding quality, quality assurance and quality control principles and techniques across the relevant technical domains (e.g., security, privacy, etc.)

TITLE	ROLES AND RESPONSIBILITIES	EXPECTED QUALIFICATIONS
Subject Matter Expert	Subject Matter Experts (SME) provide specialized knowledge and expertise in areas required to fully verify development methodology or approach, or validate final products for compliance and functionality and/or QC tasks that need to be performed. SMEs may be used to augment the core IV&V team to provide highly-specialized services.	• Demonstrates significant experience with the specified architectural/design concepts (e.g. service-oriented architecture) and technologies in use on this project and Program as they relate to their area of expertise • Demonstrates significant experience with relevant industry-standards and best practices regarding quality and quality assurance or control principles and techniques across the relevant domains (PMBoK, IEEE, CMMI, etc.) • Should demonstrate experience with transitioning data from legacy or existing system to new systems • Demonstrate knowledge/experience with health informatics particularly for Care Management • Demonstrates clinical expertise

3.4.1.2.2 Vendor Subject Matter Expertise

The following expertise should be demonstrated in the Vendor response within the roles of Key Project Personnel for this project, supplemented with Subject Matter Experts where necessary. The Vendor may propose additional subject matter expertise particularly in matters where more detailed QC activities are deemed required as expected to be needed for this project.

In particular for the following areas of activity:

- **Medicaid Business Processes** as described in the MMIS, Care Management and PBM RFPs (includes business processes such as contact center activities, claiming, payment and fund management in addition to many others) and Program (Business) Integration Management across the Contract Work Streams
- Communications Management
- Development Strategies and Methodologies

- **System Design, Development/Configuration and Implementation**
- **Development and Operational Environments**
- **Data Conversion, Structures and Management Methodologies** (to include transitioning data from a legacy or existing system to a new system)
- **Interfaces and Integration**
- **System and Acceptance Testing** (including Unit, Integration, Regression, User Acceptance, etc.)
- **Documentation and Knowledge Management**
- **Training and Knowledge Transfer**
- **Functional and Technical Operations**
- **Transition to Operations**

In addition to these other areas as required:

- Project and Program Governance
- Functional and Non-Functional Requirements Management and Validation Methods (Testing, Simulations, Analysis)
- Software Estimating Models/Methods
- Software Design Tools/Methodologies
- DDI Project Management including at least:
  - Schedule Management
  - Scope Management
  - Budget Management
  - Risk Management
  - Quality Management
  - Communications Management
  - **Integration Management**
- Operations Oversight Including Performance Management

- **CMS Seven Conditions and Standards and Technical Capabilities**
- Security and Privacy
- Business Intelligence and Reporting
- Information Management
- Networking Architectures and Capabilities
- Shared Services
- Hosting

The State recognizes that it may need additional expertise to support QA/IV&V of the Medicaid Projects. As part of the contract resulting from this RFP, the Vendor and State may establish task-based change orders for services to support specific tasks as they are identified. In addition, the Vendor may be asked to provide cross-procurement support for business, technical and/or process to ensure coordination across the individual projects in addition to the scope currently defined within this RFP.

The type of subject matter expertise the State may request from the vendor is listed below. The Vendor should describe additional capabilities they can offer to support the project needs in these areas:

- Clinical (e.g. Pharmacy knowledge, Care protocols)
- Medicaid business processes (e.g. all MITA business processes and information/technical business process areas)
- Functional DDI support (e.g., requirements definition, testing, training)
- Technical DDI support (e.g. technical requirements validation, integration, testing, security, privacy, etc.)
- Multi-vendor oversight within the Medicaid procurements, and with other procurements

The response to this RFP should include a description of the expertise that the Vendor can use to address potential State needs, as well as a cost schedule for experience levels of subject matter experts that the Vendor may use. The capability of the vendor to provide subject matter expertise to support project needs will be an evaluated part of the response, however the cost schedule will not be evaluated as part of responses and will be discussed prior to and after contract completion.

3.4.2 Location of Contracted Functions and Personnel

The State will provide office space for a maximum of four consultants when project staff is on-site.

3.5 Proposed Project Schedule

The State anticipates the awarded Vendor will begin work by December 15, 2014. The schedule and scope of the QA/IV&V tasks and deliverables described within this document are subject to change based upon the actual status of each Medicaid Project at the time of QA/IV&V contract award.

The Vendor's QA/IV&V tasks shall support the State's actual schedule for each Medicaid project. The Vendor's must review the schedule of each Medicaid Project to determine the anticipated schedule for QA/IV&V tasks and interim deadlines within the project. Additional detail on the schedule for each project is available in the associated RFP located within the Procurement Library. The estimated start and end date of each Medicaid Project is summarized in the table below.

Table 13. Medicaid Project Start

PROJECT	ESTIMATED START DATE	ESTIMATED END DATE
Medicaid Management Information System (MMIS), Medicaid Operations Services (MOS)	Spring 2015	January 1, 2017
Integrated Contact Center System	Spring 2015	June 2015
Care Management Solution	Fall 2014	Summer 2015
Pharmacy Benefit Management Solution	Currently Underway	December 31, 2014

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4.0 Proposal Evaluation

The State will use a formal evaluation process to select the successful Vendor(s). The State will consider capabilities or advantages that are clearly described in the Proposal, which may be confirmed by key personnel interviews, oral presentations, site visits, demonstrations, and references contacted by the State. The State reserves the right to contact individuals, entities, or organizations that have had dealings with the Vendor or proposed staff, whether or not identified in the Proposal.

The State will more favorably evaluate proposals that offer no or few exceptions, reservations, or limitations to the terms and conditions of the RFP, including the State's General Provisions.

4.1 Evaluation Criteria

The State will evaluate proposals in the context of the best value overall approach for entirety of the systems and services requested. The State will, at its discretion, select one or more Vendors that provide the overall best value for these components.

The State will evaluate proposals based on the following best value evaluation criteria:

- Vendor Experience, including:
  - Relevant Vendor Experience
  - Customer References
- Project Staff and Project Organization, including:
  - Project Organization
  - Key Project Personnel Experience
- Services, including:
  - Approach
  - Deliverables
  - Requirements
- Cost

4.2 Initial Compliance Screening

The State will perform an initial screening of all proposals received. Unsigned proposals and proposals that do not include all required forms and sections are subject to rejection without

further evaluation. The State reserves the right to waive minor informalities in a proposal and award contracts that are in the best interest of the State of Vermont.

Initial screening will check for compliance with various content requirements and minimum qualification requirements defined in the RFP. The State reserves the right to request clarification from Vendors who fail to meet any initial compliance requirements prior to rejecting a proposal for material deviation from requirements or non-responsiveness.

4.3 Minimum Mandatory Qualifications

If the Vendor (Prime and/or Subcontractor) does not maintain these credentials or cannot demonstrate compliance with all of these requirements to the State, the Vendor's Proposal may be rejected.

- The Vendor must be independent (e.g., technically, managerially and financially) from the State and DDI Vendor(s)
    - Technically, the Vendor must not be or have been involved, nor use personnel who are or were involved, in the software development or implementation effort described in the IE, MMIS, PBM or Care Management RFPs, or participated in the projects' initial planning and/or subsequent design.
    - Managerially, the Vendor must be departmentally and hierarchically separate from the software development organizations.
- The Vendor must demonstrate at least five (5) years' successful experience delivering QA/IV&V services for large HHS projects that included QA/IV&V of design, development and implementation activities
- The Vendor must demonstrate successful experience with State or Federally funded projects and associated regulatory requirements; understanding of the CMS Certification process, CMS Seven Conditions and Standards including the MITA framework
- The Vendor must have expertise in evaluating the use of current information technologies (e.g. service oriented architecture, virtualization, rules engines, security) in large-scale systems
- The Vendor must submit at least three (3) references using Template C to verify the Vendor's experience in QA/IV&V of the design, development and implementation of at least three (3) solutions similar in size, complexity and scope to this procurement in the last five (5) years

The Vendor must demonstrate compliance with the above mandatory requirements in Response Template A – Cover Letter and Executive Summary.

4.4 Competitive Field Determinations

The State may determine that certain proposals are within the field of competition for admission to discussions. The field of competition consists of the proposals that receive the highest or most satisfactory evaluations. The State may, in the interest of administrative efficiency, place reasonable limits on the number of proposals admitted to the field of competition.

Proposals that do not receive at least a defined number of the evaluation points for each of the evaluation criteria, may, at the sole discretion of the State, be eliminated from further consideration.

4.5 Oral Presentations and Site Visits

The State may, at its sole discretion, request oral presentations, site visits, and/or demonstrations from one or more Vendors admitted to the field of competition. The Key Personnel as identified in the Vendor's Proposal must be active participants in the oral presentations – the State is not interested in corporate or sales personnel being the primary participants in oral presentations. This event, if held, will focus on an understanding of the capabilities of the Vendor and importantly identified key personnel's ability to perform consistent with the Vendor's Proposal in meeting the State's requirements. The State will notify selected Vendors of the time and location for these activities, and may supply agendas or topics for discussion. The State reserves the right to ask additional questions during oral presentations, site visits, and/or demonstrations to clarify the scope and content of the written Proposal.

The Vendor's oral presentation, site visit, and/or demonstration must substantially represent material included in the written Proposal, and should not introduce new concepts or offers unless specifically requested by the State.

4.6 Best and Final Offers

The State may, but is not required to, permit Vendors to prepare one or more revised offers. For this reason, Vendors are encouraged to treat their original Proposals, and any revised offers requested by the State, as best and final offers.

4.7 Discussions with Vendors

The State may, but is not required to, conduct discussions with all, some, or none of the Vendors admitted to the field of competition for the purpose of obtaining the best value for the State. It may conduct discussions for the purpose of:

- Obtaining clarification of Proposal ambiguities;
- Requesting modifications to a Proposal; and/or
- Obtaining a best and final offer.

The State may make an award prior to the completion of discussions with all Vendors admitted to the field of competition if the State determines that the award represents best value to the State of Vermont.

4.8 Award Determination

All purchases, leases, or contracts, which are based on competitive proposals, will be awarded according to the provisions in the Request for Proposal. The Procurement Team will evaluate the proposals based on responsiveness to RFP key points and forward the completed scoring tools as well as copies of the proposals to the Deputy Commissioner for final review and determination of any award.

The State reserves the right to waive any deviations or errors that are not material, do not invalidate the legitimacy of the proposal, and do not improve the bidder's competitive position. All awards will be made in a manner deemed in the best interest of the State.

4.9 Notification of Award

DVHA will notify all bidders in writing of an award determination. DVHA will notify all bidders when the contract(s) resulting from this RFP are signed by posting to the Electronic Bulletin Board (http://www.vermontbidsystem.com).

5.0 Glossary of Acronyms and Terms

A

ACCESS: State of Vermont's current Integrated Eligibility System

Ad Hoc Query: Queries created by users to obtain information for a specific need as it arises

Affordable Care Act (ACA): On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act. On March 30, 2010, the Health Care and Education Reconciliation Act of 2010 was signed into law. The two laws are collectively referred to as the Affordable Care Act (ACA). The Affordable Care Act expands Medicaid eligibility: effective on January 1, 2014, Medicaid will be available for the first time to individuals without minor children earning less than one hundred thirty-three percent (133%) of the Federal poverty level (FPL).

Agency of Human Services (AHS; "the Agency"): Vermont's agency that administered the majority of the State's health and human services programs. AHS is the State's Single Medicaid Agency

ARIS: ARIS Solutions is a 501(C)3 non-profit corporation that provides fiscal agent services within Vermont

B

Blueprint for Health ("Blueprint"): The Blueprint for Health (Blueprint) is Vermont's state-led initiative charged with guiding a process that results in sustainable health care delivery reform. Originally codified in Vermont statute in 2006, then modified further in 2007, 2008, and finally in 2010 with Vermont Act 128 amending 18 V.S.A. Chapter 13 which defines Blueprint as a "program for integrating a system of health care for patients, improving the health of the overall population, and improving control over health care costs by promoting health maintenance, prevention, and care coordination and management."

Business Intelligence (BI): The process or capability of gathering information in the field of business; the process of turning data into information and then into knowledge

Business Process Analysis: Methodology used for developing a system's Functional Requirements by establishing an understanding of the as-is environment and identifying the to-be operational business and service delivery processes of the future system

C

Care Management: A future solution that will be used to provide early identification of Medicaid member healthcare needs, coordination of care and results reporting

Cash Management Improvement Act: The Cash Management Improvement Act of 1990 (CMIA) provides rules and procedures for the efficient transfer of federal financial assistance between the federal agencies and the State

Catamount Health: A health insurance plan, offered in cooperation with the state of Vermont, by Blue Cross Blue Shield of Vermont and MVP, which ended on 3/31/14 due to implementation of the ACA

Contact Center: A portion of this RFP that manages inbound and outbound calls, outgoing mail, and specific processes for members and providers

Centers for Medicare and Medicaid Services (CMS): A federal agency within the United States Department of Health and Human Services (DHHS).

Clawback: The mechanism through which the states will help finance the new Medicare drug benefit is popularly known as the "clawback" (the statutory term is "phased-down State contribution").

Commercial Off-The-Shelf (COTS): Ready-made software applications

Common Enterprise Portal: Enterprise portals are a type of composite application that pre-integrates the services needed to build contextual websites

Contract: Binding agreement between the State of Vermont and the awarded Vendor.

Coordination of Benefits: allows plans that provide health and/or prescription coverage for a person with Medicare or any other insurance to determine their respective payment responsibilities (i.e., determine which insurance plan has the primary payment responsibility and the extent to which the other plans will contribute when an individual is covered by more than one plan).

Coordination of Benefits Unit (COB): a unit of DVHA responsible for coordinating benefits across payers to ensure Medicaid is the payer of last resort. COB activities include but are not limited to, estate recovery, casualty recovery, and HIPP

Collaborative Application Lifecycle Tool (CALT): CALT is a collaborative tool that creates a centralized repository for storing, collaborating on and sharing deliverables and artifacts from IT projects in support of Medicaid administration and establishment of Exchanges

Community Rehabilitation and Treatment (CRT): Vermont's Community Rehabilitation and Treatment programs assist adults that have been diagnosed with a mental illness. Symptoms may be mild or substantially disabling, and long-term or short term.

Customers: Providers, Members, AHS and other System users

Customer Support Representative (CSR): Customer-facing service representatives employed by the State or by a partner Vendor, please note in this document CSR can also mean Change System Request

D

Dashboards: Display Key Performance Indicators (KPIs) or business metrics using intuitive visualization, including dials, gauges and traffic lights that indicate the state of various KPIs against targets

DDI Vendor: Systems Integrator(s) that is awarded the contract to provide the solution

Deliverable Expectations Document (DED): A document approved by the State to guide the development of deliverables created by a Vendor

Department for Children and Families (DCF): The State's eligibility and enrollment for Medicaid and all public assistance programs are administered by DCF including but not limited to, 3SquaresVT (SNAP), Reach Up (TANF) and General Assistance

Department of Corrections (DOC): A department within AHS charged with overseeing the state correctional facilities, supervising probation and parolees, and serving in an advisory capacity in the prevention of crime and delinquency

Department of Disabilities, Aging and Independent Living (DAIL): A department within AHS responsible for all facility-based and community-based long-term care services for older Vermonters, individuals with developmental disabilities, traumatic brain injuries, and physical disabilities

Department of Health and Human Services (DHHS): The Department of Health and Human Services is the United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves

Department of Information and Innovation (DII): The State department overseeing technology and technology implementations

Design, Development and Implementation (DII): The common term for the project based work to stand up technology and/or services

Department of Mental Health (DMH): DMH administers mental health programs across the State through multiple programs for both adult and children's services, including but not limited to CRT, Child, Adolescent and Family Mental Health Services and Enhanced Family Treatment

Department of Vermont Health Access (DVHA): DVHA administers nearly all of the publicly funded health care programs for the State of Vermont

Designated Agency (DA): Private, non-profit service providers called located throughout the state. The Department of Mental Health designates one Designated Agency (DA) in each geographic region of the state as responsible for ensuring needed services are available through local planning, service coordination, and monitoring outcomes within their region.

Disproportionate Share Hospital (DSH): The Medicare DSH adjustment provision under section 1886(d) (5) (F) of the Act was enacted by section 9105 of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 and became effective for discharges occurring on or after May 1, 1986.

Designated State Health Program (DSHP): Programs approved to be DSHPs funded by Medicaid funds

Dual Eligible: A member with both Medicare and Medicaid

E

Early Periodic Screening, Diagnosis, and Treatment (EPSDT): services to achieve proper growth and development or prevent the onset or worsening of a health condition provided by the State for any child under 21 years of age eligible under the State plan in a category under section 1902(a)(10)(A) of the Act.

Edit: Edit verifies information on a single claim based on accuracy, validity, required presence of allowable values, and integrity of data submitted

Electronic Medical Record (EMR): A software package that electronically manages the storage and retrieval of medical records

Enrolled Provider: an individual, group, company or business under contract with the State to deliver a service(s) or product

Enterprise Architecture (EA): The competency of integrating business, information, application and technology to a cohesive goal

Enterprise Project Management Office (EPMO): Part of DII; The State oversight project management office

Enterprise Service Bus (ESB): A software construct found in a Service-Oriented Architecture that provides fundamental services via a messaging engine

External Quality Review Organization: EQEO, Federal regulations require that states which contract with Medicaid Managed Care Organizations (MCO) or Prepaid Inpatient Health Plans

(PIHP) conduct an External Quality Review (EQR) of each entity. States may perform EQR tasks directly, or may contract with independent entities called External Quality Review Organizations (EQRO) to conduct the external quality review.

F

Financial Budget Report (FBR): A financial budgeting and tracking tool

Federal Data Hub: A data services hub to help states verify the income, citizenship and other information about individuals when they seek health coverage through health insurance exchanges and for Medicaid and Children's Health Insurance Programs

Federal Financial Participation (FFP): The rate and amount the Federal government provides for Medicaid activities within the State

Federal Information Security Management Act (FISMA): The Federal Information Security Management Act of 2002 ("FISMA", 44 U.S.C. § 3541, et seq.)

Federally Qualified Health Centers (FQHC): Federally designated health organizations that provide health care regardless of a person's ability to pay

Fee-for-Service (FFS): A reimbursement methodology used in health care

Fiscal Agent (FA): The services the Vendor is expected to provide that supports the claiming and fiscal matters on behalf of the State. The Vendor is expected to be the auditable source for the finances of the State.

G

Global Commitment to Health Waiver: As part of the State Fiscal Year 2006 budget proposal process, the Douglas Administration presented the Plan for Saving the Vermont Medicaid System. With this long-term strategy Vermont proposed to replace its existing section 1115a waiver, the Vermont Health Access Plan (VHAP). The replacement is the Global Commitment to Health. With the Federal approval of this proposal, certain Federal Medicaid requirements found in Title 19 of the Social Security Act are waived. The result is that the Global Commitment to Health includes the tools necessary for the state, in partnership with the Federal government, to address future needs in a holistic, global manner.

Government Accounting Office (GAO): A Federal office initially charge to investigate, at the seat of government or elsewhere, all matters relating to the receipt, disbursement, and application of public funds, and shall make to the President ... and to Congress ... reports [and] recommendations looking to greater economy or efficiency in public expenditures

Green Mountain Care Board: (GMCB): Created by the Vermont Legislature in 2011, GMCB is an independent group of five Vermonters who, with their staff, are charged with ensuring that changes in the health system improve quality while stabilizing costs.

H

Health and Human Services (HHS): The general term used to describe services provided by AHS

Health Benefits Exchange (HBE): Vermont's implementation of the Health Insurance Marketplace, entitled Vermont Health Connect

Health Information Exchange (HIE): Vermont's HIE is Vermont Information Technology Leaders

Health Insurance Portability & Accountability Act (HIPAA): A Federal act that requires specific controls for the use and sharing of data and information

Health Insurance Marketplace (HIM): Vermont's implementation of the Health Insurance Marketplace is entitled Vermont Health Connect

Health Insurance Premium Program (HIPP): A Medicaid program that provides premium assistance for a Medicaid member to enroll or remain enrolled in a private health insurance plan, if the Medicaid program finds it to be cost-effective for the program. The Omnibus Budget Reconciliation Act of 1990 (OBRA-90) authorized states to implement a HIPP program.

Health Information Exchange (HIE): Vermont's HIE is Vermont Information Technology Leaders

Health Information Technology (HIT): The general term for technology used in support of healthcare

Health Information Technology for Economic and Clinical Health Act (HITECH): The Health Information Technology for Economic and Clinical Health Act was enacted under Title XIII of the American Recovery and Reinvestment Act of 2009 (Pub.L. 111–5). Under the HITECH Act, the United States Department of Health and Human Services is spending $25.9 billion to promote and expand the adoption of health information technology

Health and Human Services Enterprise (HSE): The overreaching program structure that governs the HSE Program

Health and Human Services Enterprise Platform: HSE Platform, "the Platform," the shared services and infrastructure that will be shared across solutions.

Healthcare Common Procedure Coding System (HCPCS): A nationally known and used health care coding system

Home and Community-based Services (HCBS): Specific services approved by AHS that promotes care in the home and community

I

Identity and Access Management (IAM): The management of individual IDs, their authentication, authorization, and privileges/permissions within or across system and enterprise boundaries

Ineligible: an individual does not qualify for Public Assistance at either initial or subsequent re-determination

Information Systems Division (ISD): A division within DCF

Institute of Electrical and Electronics Engineers (IEEE): A standards organization

Integrated Eligibility: (IE): may refer to Vermont's Integrated Eligibility System, the functionality associated with the process of determining eligibility for multiple programs through the use of a single application or the work stream containing that functionality

Interface: A point of interaction between two systems or modules

International Standards Organization (ISO): A standards organization

Independent Verification and Validation (IV&V): Third party that oversees the project to ensure quality and timely delivery.

J

K

L

Lock-in: The act of restricting a Member's access to certain programs, services and/or Providers

M

Maintenance & Operations (M&O): A phase of a systems project that consists or maintenance and operations of those systems

Managed Care Organization (MCO): An organization that an organization that combines the functions of health insurance, delivery of care, and administration

Medicaid: Provides low-cost or free health coverage and supports for individuals with low-income: children, young adults under age 21, parents, pregnant women, caretaker relatives, people who are aged, blind or disabled

Medical Assistance Provider Incentive Repository (MAPIR): MAPIR refers to the state-level information system that currently supports the electronic health record incentive program. MAPIR will track and act as a repository for information related to payment, applications, attestations, oversight functions, and interface with CMS' National Level Repository.

Medicaid Information Technology Architecture: MITA, MITA is a reference business, information and technology architecture developed to support Medicaid across the country. Additional details can be found at: http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Medicaid-Information-Technology-architecture-MITA.html

Medicaid Management Information System (MMIS): The primary claiming and payment system for a Medicaid agency

Medicaid Operations Services: Operational support services for Medicaid and AHS operations in Vermont which includes design, development and implementation services, ongoing maintenance and operation support, and Fiscal Agent / financial support services

Member: An individual eligible and enrolled in one or more state benefits plan

Master Data Management (MDM): The competency of managing data that promotes data quality and consistency

Modified Adjusted Gross Income (MAGI): The basis for Medicaid expansion eligibility determination and a defined Internal Revenue Service term

N

Neuro-Linguistic Programming (NLP): An ontology-assisted way of programming in terms of natural language sentence

National Committee for Quality Assurance (NCQA): The National Committee for Quality Assurance is a private, 501(c) (3) not-for-profit organization dedicated to improving health care quality. Since its founding in 1990, NCQA has been a central figure in driving improvement

throughout the health care system, helping to elevate the issue of health care quality to the top of the national agenda.

National Council for Prescription Drug Programs (NCPDP): Not-for-profit, ANSI-accredited, standards development organization that provides healthcare business solutions through education and standards.

National Drug Code: NDC, National Drug Code (NDC) is a numerical code maintained by the FDA that includes the labeler code, product code, and package code. The NDC is an 11-digit code

National Information Exchange Model (NIEM): An XML-based information exchange framework from the United States representing a collaborative partnership of agencies and organizations across all levels of government (federal, state, tribal, and local) and with private industry

National Institutes of Standards and Technology (NIST): A standards organization

National Plan & Provider Enumeration System: The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of standard unique identifiers for health care providers and health plans. The purpose of these provisions is to improve the efficiency and effectiveness of the electronic transmission of health information. The Centers for Medicare & Medicaid Services (CMS) developed the National Plan and Provider Enumeration System (NPPES) to assign these unique identifiers

National Provider Identifier: The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number).

O

P

Pay and Chase: pay-and-chase occurs when States pay providers for submitted claims and then attempt to recover payments from liable third parties. States may pay and chase claims for two primary reasons: post-payment identification of TPL and Social Security Act exceptions to cost avoidance

Person-centric approach: An approach centered around the client and focused on delivering services to achieve an outcome

Pharmacy Benefits Management (PBM): A future solution that will be used to ensure the availability of clinically appropriate medication services at the most reasonable cost possible, and provide access to high quality pharmacy benefits in Vermont's publicly-funded programs

Point-of-Sale (POS): The combination of services and technology available to process a medical claim or pharmacy claim in "real time"

Portal: A computing gateway that unifies access to enterprise information and applications

Primary Care Provider (PCP) A health care practitioner who treats illnesses, provides preventive care, and coordinates the care provided by other health professionals. A PCP is usually a doctor, but may be a physician's assistant or a nurse practitioner

Primary Case Management (PCCM): A system of managed care used by state Medicaid agencies in which a primary care provider is responsible for approving and monitoring the care of enrolled Medicaid Members, typically for a small monthly case management fee in addition to fee-for-service reimbursement for treatment

Prior Authorization (PA): a process used to assure the appropriate use of health care services. It involves a request for approval of each health service that is designated as requiring prior approval before the service is rendered.

Process Flows: A diagram depicting the set of activities required to perform a specific function in the future state

Program: Refers to the HSE Program.

Project Information Library: A comprehensive collection of project documentation.

Program Integrity (PI): The Affordable Care Act includes numerous provisions designed to increase program integrity in Medicaid, including terminating providers from Medicaid that have been terminated in other programs, suspending Medicaid payments based on pending investigations of credible allegations of fraud, and preventing inappropriate payment of claims under Medicaid

Project Management Body of Knowledge (PMBOK): A comprehensive knowledge center developed and maintained by the Project Management Institute

Project Management Institute (PMI): A certifying agency that specializing in project management

Project Management Office (PMO): An organization that manages projects

Project Management Plan (PMP): A comprehensive plan for the execution of a project; includes multiple sub-plans that address specific project management aspects

Proposal: An offer from the State requesting specific services to a prospective Vendor

Provider: an individual, group, company or business that supplies a service(s) or product

Q

Quality Assurance (QA): a program for the systematic monitoring and evaluation of the various aspects of a project, service, or facility to ensure that standards of quality are being met

R

Reach Up: Reach Up is the implementation of TANF in Vermont; it helps families with children by providing cash assistance for basic needs and services that support work and self-sufficiency

Remittance Advice (RA): Documentation of remittances issues to payment recipients

Requirements: Detailed list of requirements necessary for the proposed solution

Requirements Traceability Matrix (RTM): A detailed list of requirements, along with their source, that tracks the functionality and other requirements a system needs to provide

Request for Proposal (RFP): A document that details the proposal that a vendor must submit to an issuer

S

Service-Oriented Architecture (SOA): A set of design principles used in application development characterized by the following attributes:

1. The system must be modular. This provides the obvious benefit of being able to "divide and conquer" — to solve a complex problem by assembling a set of small, simple components that work together
2. The modules must be distributable — that is, able to run on disparate computers and communicate with each other by sending messages over a network at runtime
3. Module interfaces must be "discoverable" — that is, clearly defined and documented. Software developers write or generate interface metadata that specifies an explicit contract, so that another developer can find and use the service
4. A module that implements a service must be "swappable." This implies that it can be replaced by another module that offers the same service without disrupting modules

that used the previous module. This is accomplished by separating the interface design from the module that implements the service

5. Service provider modules must be shareable — that is, designed and deployed in a manner that enables them to be invoked successively by disparate applications in support of diverse business activities

Seven Conditions and Standards: CMS published guidance entitled *The Seven Conditions & Standards for Enhanced Funding*, which lists requirements that states must meet to leverage the 100%, 90/10, and other federally matched funding streams that support the ACA. The Seven Standards serve as a touchstone for the modular, flexible, interoperable design of the Health and Human Services Enterprise and its emphasis on reusability of portfolio components.

Shared Analytics: Refers to the business intelligence functionality or the work stream containing that functionality

Shared Savings Plan (SSP): A CMS established program to facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service members and reduce unnecessary costs

Social Security Administration (SSA): Delivers services through a nationwide network of over 1,400 offices that include regional offices, field offices, card centers, tele-service centers, processing centers, hearing offices, the Appeals Council, and our State and territorial partners, the Disability Determination Services

Social Security Number (SSN): A nine-digit number assigned to citizens, some temporary residents and permanent residents in order to track their income and determine benefit entitlements

Social Services Management Information System (SSMIS): System for the management services in the Department for Children and Families, Family Services Division

Software Development Lifecycle (SDLC): A common framework for systems development

Software Engineering Institute (SEI): The Carnegie Mellon Software Engineering Institute (SEI) works closely with defense and government organizations, industry, and academia to continually improve software-intensive systems. Our core purpose is to help organizations such as yours to improve their software engineering capabilities and to develop or acquire the right software, defect free, within budget and on time, every time

Solution: A combination of system(s) and services that meet the needs of the documented functional and non-functional requirements in the context of the goals and objectives of AHS, as detailed in this RFP

Stakeholder: A stakeholder is anybody who can affect or is affected by an organization, strategy or project

State Innovation Model (SIM): The State Innovation Models Initiative is providing up to $300 million to support the development and testing of state-based models for multi-payer payment and health care delivery system transformation with the aim of improving health system performance for residents of participating states. Projects are broad based and focus on people enrolled in Medicare, Medicaid and the Children's Health Insurance Program (CHIP). In Vermont this is referred to as the Vermont Healthcare Innovation Project (VHCIP)

State of Vermont ("State", "the State" or "Vermont"): The State issuing this RFP

State Medicaid Agency (SMA): The single agency within a state that manages the Medicaid program for that state

Subject Matter Expert (SME): An expert in a specific subject area

Success Beyond Six: The Agency of Human Services and the Agency of Education established a Success Beyond Six Legislative Study Group to help respond to the legislative charge from the 2007 sessions' appropriation bill. The work group was made up of individuals from various mental health and education perspectives. The charge from the legislature was to ensure that expenditures through the Success Beyond Six funding mechanism: Utilize best practices; Yield positive outcomes; and are managed to a predictable rate of growth.

Supplemental Nutrition Assistance Program (SNAP): A program that offers nutrition assistance to eligible, low-income individuals and families and provides economic benefits to communities. SNAP is the largest program in the domestic hunger safety net. Vermont's SNAP program is referred to as 3SquaresVT

Supplemental Security Income (SSI): a program through the Social Security Administration that pays benefits to disabled adults and children; with limited income and resources.

Surveillance and Utilization Review Subsystem: SURS, MMIS subsystem which applies automated post-payment screens to Medicaid claims adjudication to identify aberrant billing patterns, which may be fraud or provider abuse

System: A combination of software, applications (e.g. claims processing application, provider management application), and technology infrastructure.

T

Temporary Assistance for Needy Families (TANF): One of the United States of America's federal assistance programs. It began on July 1, 1997, and succeeded the Aid to Families with

Dependent Children (AFDC) program, providing cash assistance to indigent American families with dependent children through the United States Department of Health and Human Services. Vermont's TANF program is referred to as Reach Up.

U

User Acceptance Test (UAT): Testing by users with the intent of acceptance of a system by the client

V

Validation: Confirmation by examination and provisions of objective evidence that the particular requirements for a specific intended use are fulfilled; Ensuring the right product is built

VISION: (Vermont Integrated Solution for Information and Organizational Needs) is an Oracle/PeopleSoft enterprise financial management system also administered by the Department of Budget and Management

Vendor: The QA/IV&V provider that is awarded the contract to provide the QA/IV&V services

Vendor, DDI: Systems Integrator(s) that is awarded the contract to provide the solution

Verification: Confirmation by examination and provisions of objective evidence that specified requirements have been fulfilled; Ensuring the product is built right

Vermont Chronic Care Initiative (VCCI): A Health Care Reform strategy for Medicaid that provide targeted care management for a subset of the Vermont population

Vermont Health Access Plan (VHAP) is a health insurance program for adults age 18 and older who meet income guidelines. This program ended on March 31, 2014 due to the implementation of the ACA.

Vermont Health Connect (VHC): Vermont's implementation of a health insurance marketplace, also commonly referred to as the Health Benefits Exchange

Vermont Health Information Technology Plan: Vermont Health Information Technology Plan (VHITP) is the operational planning document that contains the Health Information Technology (HIT) and Health Reform Information Technology systems

Vermont Healthcare Innovation Project (VHCIP): Vermont's implementation of the State Innovation Model

Vermont Information Technology Leaders (VITL): VITL is a 501(c) (3) non-profit organization that assists Vermont health care providers with adopting and using health information technology to improve patient care. VITL began as a project of the Vermont Association of Hospitals and Health Systems and was spun off as a separate entity in July 2005

VPHARM: Assists Vermonters who are enrolled in Medicare Part D with paying for prescription medicines. This includes people age 65 and older as well as people of all ages with disabilities up to 225% of the federal poverty level (FPL).

W

Web Services: Web services are modular business services delivered over the Internet as and when needed. The modules can be combined, can come from any source, and can eventually be acquired dynamically and without human intervention, when needed. They are a key building block of a Service-Oriented Architecture

Work: "The Work" in this RFP is defined as project services and ongoing operational and hosting services.

Work Breakdown Structure: WBS

X

Y

Z